

# MARYLAND

STATE MEDICAL JOURNAL

VOLUME 20 NUMBER 1  
JANUARY 1971

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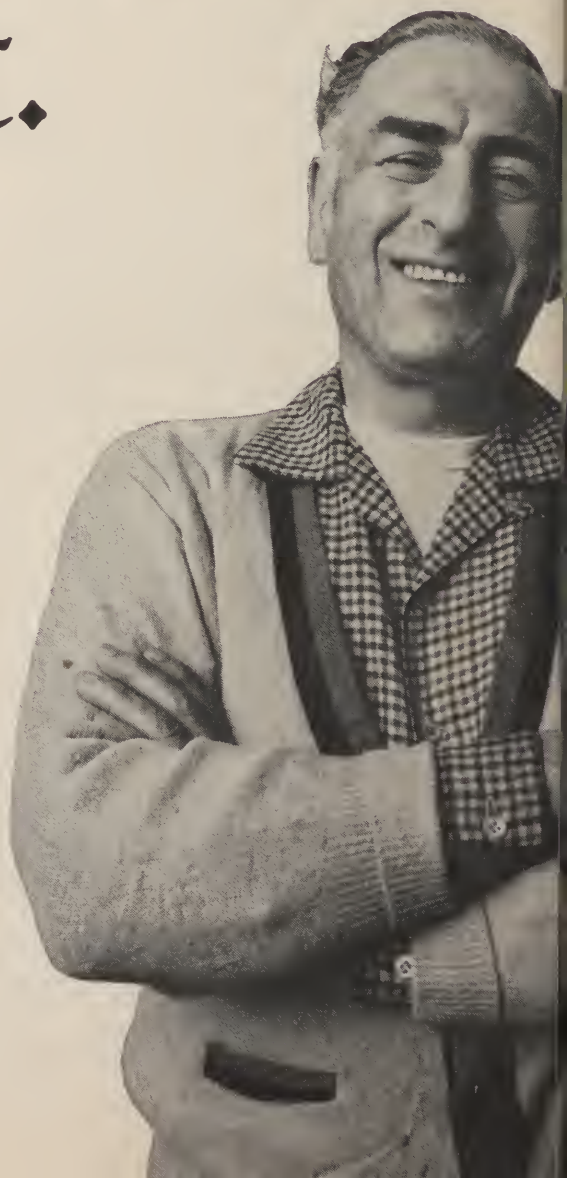
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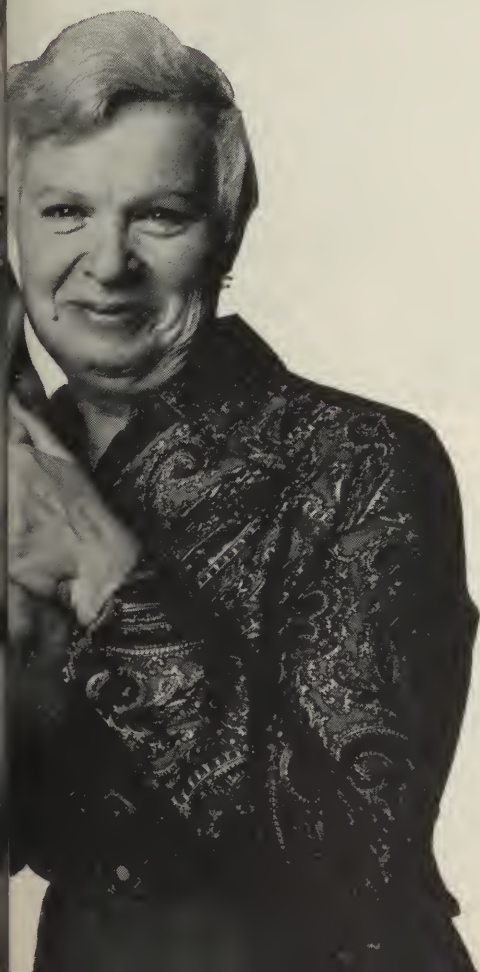




His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

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**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

**Contraindications:** Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

**Precautions:** In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

**Adverse Reactions:** Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

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# maryland state MEDICAL JOURNAL

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**ON THE COVER:** This month's cover of the McDonogh School Chapel was photographed by **J. Steven Lovejoy**, a part-time employee of the Med-Chi Library. He is majoring in theatre arts at Towson State College, and manages "3803 Presents", an independent young people's repertory theatre company in Baltimore.



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# Doctors take note...

## **JANUARY 18, 1971 HEART ASSOCIATION OF MARYLAND**

Seminar for Aides and Attendants—Helping the Heart Attack Patient: Cambridge, Maryland. Contact: Heart Association of Maryland, 415 N. Charles Street, Baltimore, Maryland 21201.

## **JANUARY 18-22, 1971 AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Recent Advances in Internal Medicine: Augusta, Georgia. Contact: American College of Physicians, 4200 Pine St., Philadelphia, Pa.

## **JANUARY 20-22, 1971 AMERICAN DIABETES ASSOCIATION/MAYO CLINIC, MAYO FOUNDATION/UNIVERSITY OF MINNESOTA SCHOOL OF MEDICINE AND HEALTH SCIENCE CENTER**

18th Postgraduate Course—Diabetes in Review: Clinical Conference 1971: Kahler Hotel, Rochester, Minnesota. Sessions of the course will include a variety of subjects; workshops are being planned. Registration fee: \$75 for members of the association; \$100 for nonmembers. The course is accredited by the American Academy of General Practice for 17 hours of elective credit. Among the speakers will be Thaddeus E. Prout, MD, of the Greater Baltimore Medical Center in Baltimore. For further information, contact: J. Richard Connelly, Executive Director, American Diabetes Association, Inc., 18 East 48th St., New York, N. Y. 10017.

## **FEBRUARY 4, 1971 UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE**

Postgraduate Course—Gynecology Day: University of Maryland, Baltimore, Md. Contact: University of Maryland School of Medicine, 522 West Lombard St., Baltimore, Md. 21201.

## **FEBRUARY 5-7, 1971 AMERICAN COLLEGE OF PHYSICIANS/AMERICAN ACADEMY OF PEDIATRICS**

Postgraduate Course—Recent Advances in Immunoprophylaxis and Chemotherapy of Infectious Diseases: Hilton Inn, 1601 Miracle Mile Strip, Tucson, Arizona. The University of Arizona College of Medicine will participate. For further information, contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

## **FEBRUARY 7, 1971 MARYLAND THORACIC SOCIETY**

11th Annual Scientific Session: Sheraton-Baltimore Inn, Broadway & Orleans Sts., Baltimore, Md. Contact: Mrs. Ruth M. Disney, Administrative Assistant, 11 East Mount Royal Ave., Baltimore, Md. 21202.



**FEBRUARY 15-18, 1971**

**AMERICAN COLLEGE OF CHEST PHYSICIANS**

Postgraduate Course—Cardio-Respiratory Care—An Advanced Course for Nurses: Los Angeles, California. Contact: American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

**FEBRUARY 17-19, 1971**

**AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Medical Complications in Pregnancy: Ambassador Hotel, 3400 Wilshire Blvd., Los Angeles, Calif. Contact: Phil R. Manning, MD, FACP, or Edward J. Quilligan, MD, Co-directors, University of Southern California, Los Angeles, California.

**FEBRUARY 18-24, 1971**

**MARQUETTE SCHOOL OF MEDICINE**

4th Annual Postgraduate Course in Gynecological Pathology, Cytogenics, and Endocrinology: Pfister Hotel, Milwaukee, Wisconsin. Contact: Richard F. Mattingly, MD, Professor and Chairman, Department of Gynecology and Obstetrics, 8700 W. Wisconsin Ave., Milwaukee, Wisconsin 53226.

**FEBRUARY 20-21, 1971**

**AMERICAN ACADEMY OF ALLERGY**

Postgraduate Course—27th Annual Meeting: Palmer House, Chicago, Illinois. Arthur M. Silverstein, MD, of the Wilmer Ophthalmological Institute of The Johns Hopkins University School of Medicine, Baltimore, Md., will participate in the session on New Developments in Cellular Immunology. Contact: American Academy of Allergy, 756 N. Milwaukee St., Milwaukee, Wisc. 53202.

**FEBRUARY 20-27, 1971**

**AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS/COLLEGE OF AMERICAN PATHOLOGISTS**

Joint Interim Meeting: The Dunes, Las Vegas, Nevada. Contact: The American Society of Clinical Pathologists, The Secretariat, 710 South Wolcott Avenue, Chicago, Ill. 60612.

**FEBRUARY 21-26, 1971**

**AMERICAN ACADEMY OF FORENSIC SCIENCES**

23rd Annual Program: Phoenix, Arizona. Contact: American Academy of Forensic Sciences, 750 Main Street, Suite 1000, Hartford, Conn. 06103.

**FEBRUARY 22-26, 1971**

**AMERICAN COLLEGE OF SURGEONS**

5th International Congress of Plastic and Reconstructive Surgery: Melbourne, Australia. Contact: American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

**MARCH 11-12, 1971**

**UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE**

Postgraduate Course—Current Advances in Practical Neurology: University of Maryland, Baltimore, Md. Contact: University of Maryland School of Medicine, 522 West Lombard St., Baltimore, Md. 21201.



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# executive director's newsletter

January, 1971

## AIR POLLUTION CRISES

The Faculty's Executive Committee in related actions has distributed a press release to all communications media in the State with a sample statement to the public in connection with Air Pollution crises.

The statement deals with what patients with specified diseases should do during an air pollution crisis.

At the same time, approval was given to the following statement for the use of physicians, in treatment of such patients during such a crisis. It is considered a guideline only, actual treatment varying with the individual patient:

In the course of treatment of common respiratory conditions during periods of Air Pollution Crises there should be increased use of moist inhalations, bronchodilators, broad spectrum antibiotics during and for several days after air pollution episodes have abated. Cough suppressants, antihistamines and sedatives in general contribute to allowing secretions to build up and precipitate acute respiratory failure by suppressing ventilatory drive, and should be judiciously avoided during this period. The use of corticosteroids may be helpful for a short period. Hospitalization is necessary for an intense pulmonary regimen, particularly for severe hypoxia and hypercapnia. The latter may be better identified by arterial blood gases.

## LEGAL ABANDONMENT

The Faculty office receives many inquiries regarding what constitutes legal abandonment. In an attempt to clarify this situation, a definition has been provided by the Faculty's legal counsel and appears on page 13 of the Journal.

## NEW CRITERIA FOR SPECIAL DIETS FOR PUBLIC ASSISTANCE RECIPIENTS

The following information has been provided by the Department of Social Services in connection with new criteria medically-prescribed diets for Public Assistance Recipients:

Special diet application forms (#780) may be obtained on request from local social services departments and kept in quantity in physicians offices.



NEW CRITERIA FOR  
SPECIAL DIETS  
FOR PUBLIC ASSISTANCE  
RECIPIENTS  
(cont'd)

This self-explanatory form requires a diagnosis as related to the diet prescribed, designation of the type of diet, and the length of time for which the diet will be needed. Special diets are allowable for: atherosclerosis, congestive heart failure, hypertension, hypertensive cardiovascular disease, diabetes, gall bladder disease, gastrointestinal diseases, kidney diseases, liver diseases, and renal failure.

Recipients who require a modified diet as therapy for food allergies, inborn errors of metabolism, malabsorption syndromes, and other special conditions, may also be entitled to special diet funds. Since the allowance made is based upon the cost of the foods required, it is necessary for the physician to specify exactly what diet he has prescribed for his patient.

A new eligibility category has been established to provide extra funds for malnourished children and adults. To qualify, the applicant, if under thirteen years of age, must have a current hemoglobin of 10 grams or less and be at or below the tenth percentile in either height or weight. Patients over thirteen, whose hemoglobin is 10 grams or less, are also eligible.

RECOMMENDED  
PROCEDURE

The Faculty has endorsed the concept that routine STS and Rubella HIA tests be performed on all prenatal patients.

DUES  
BILLS

Dues bills, prepared from Faculty computer records, have been mailed to all members. Dues must be paid by January 31, 1971 in order for members to be eligible for legal defense as provided in the Faculty's Bylaws.

  
Executive Director



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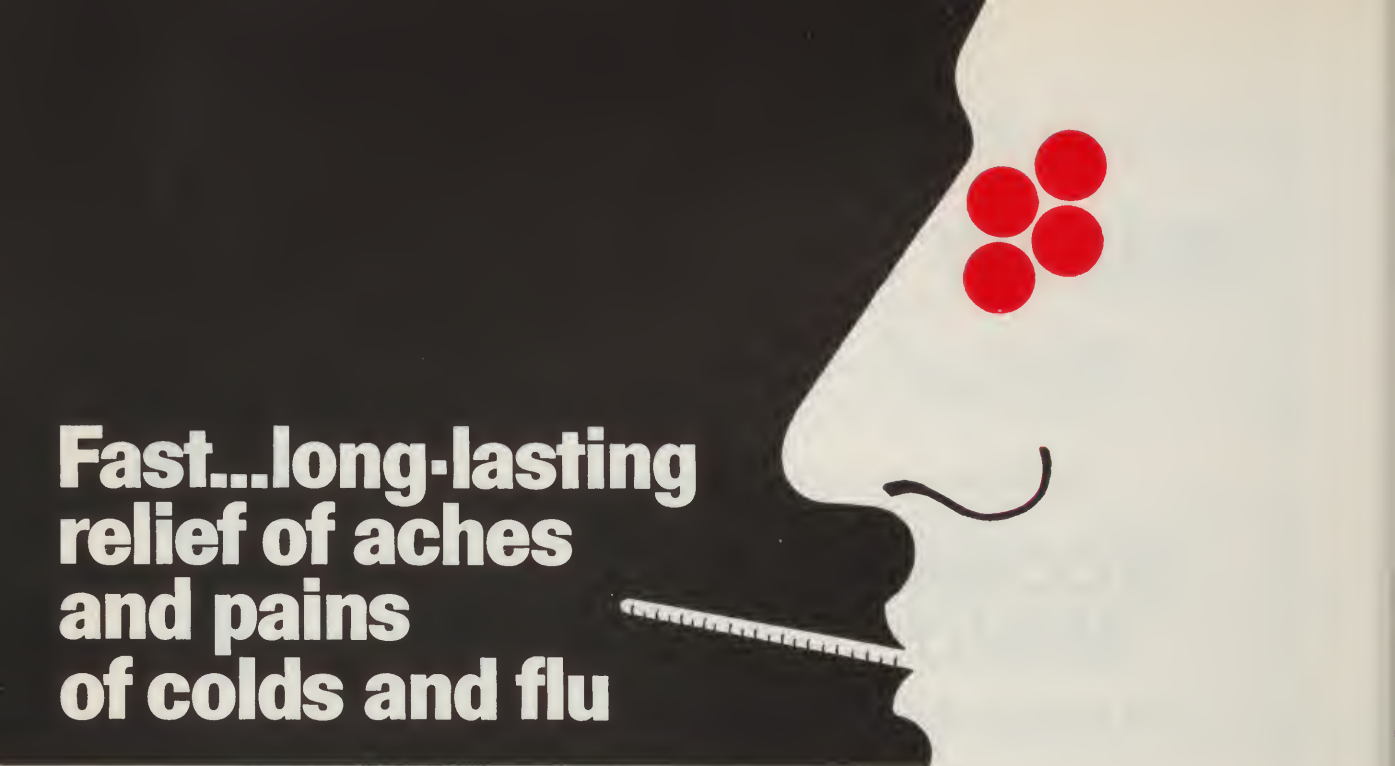
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# Abandonment Defined

The term "abandonment" means the unilateral severance by the physician of the professional relationship between himself and the patient without reasonable notice at a time when there is still the necessity of continuing attention. The termination of the relationship to constitute abandonment must be by a unilateral act of the physician. There can be no abandonment if the relationship is terminated either by mutual consent or by the dismissal of the physician by the patient.

It is well recognized, however, that the physician has a right to withdraw from the case, the rule of abandonment requiring only that he give the patient reasonable notice so that the patient can secure other medical attendance, and upon such withdrawal there is no abandonment of the patient.

The corollary to the right to withdraw are the following duties:

(a) Duty to continue treatment: If a physician abandons a case without giving notice or providing a competent physician in his place, it is a failure to exercise that care required by law.

(b) Duty of postoperative care: When a surgeon performs an operation not only must he use reasonable care and skill in its performance, but also in subsequent treatment of the case, it is his duty to give the patient such attention after operation as the necessities of the case demand.

(c) Duty to give patient proper notice of intended withdrawal: A physician who leaves the patient in a critical stage of the disease without reason or sufficient notice to enable the party to procure another medical attendance is guilty of abandonment. (A physician cannot discharge a case by simply staying away without notice to the patient.)

Various types of abandonment have been recognized by the cases:

1. An express declaration by the physician that he will not further attend the patient is the clearest form of abandonment.

2. The physician's unqualified refusal to further attend to the patient's needs, even though his refusal to act is not accompanied by an express declaration that he is withdrawing from the case, is another form of abandonment.

3. Leaving the patient during or immediately after an operation is another form of abandonment.

4. Failure to attend the patient in the presence of a promise to do so likewise constitutes abandonment.

5. An unexplained failure to continue to attend the patient has been held, in a number of cases, to constitute abandonment.

6. Premature discharge of a patient will also constitute abandonment and this has been held to include the premature removal or discharge of a patient from the hospital, without adequate follow-up care.

7. Failure to give proper instructions has been held in one case sufficient to support the claim of abandonment (no instructions following treatment for broken leg, leg became bent, and finally had to be amputated).

The following have been held to be justifications for abandonment of the patient by the physician:

1. Intervening illness of the physician.

2. Lack of cooperation by the patient (*Dashiell vs. Griffith*, 84 Md. 363).

3. Limited or special employment of physician and his fulfillment of this limited or special capacity (consultation only, etc.).

Note: A lack of payment by the patient for the physician's services does not justify the physician in unilaterally terminating the relationship.



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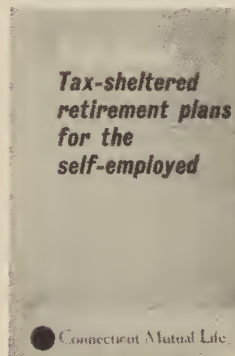
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# she has a plan that works





She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

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Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

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Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits...

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

# Ser-Ap-Es<sup>®</sup>

reserpine 0.1 mg  
hydralazine hydrochloride 25 mg  
hydrochlorothiazide 15 mg

## a plan for living with hypertension



# Ser-Ap-Es®

reserpine  
hydralazine hydrochloride  
hydrochlorothiazide

0.1 mg  
25 mg  
15 mg

**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

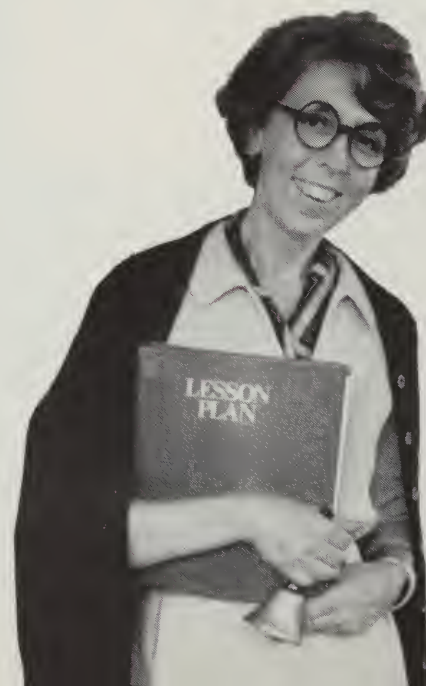
**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company  
Summit, New Jersey

2/4624



she has a plan  
that works  
for living with  
hypertension

# Ser-Ap-Es®

reserpine 0.1 mg  
hydralazine hydrochloride 25 mg  
hydrochlorothiazide 15 mg

# C I B A





ARTHUR E. COCCO, MD  
Journal Representative

## Baltimore City Medical Society

### Board of Directors Meets

The November 10 meeting of the Board of Directors was called to order by the president, John N. Classen, MD, at 4:30 PM.

The minutes of the October 13 meeting were approved as distributed.

In response to a letter from the Med-Chi Liaison Committee suggesting that the society investigate the problem of physicians referring patients to emergency rooms in the physician's absence, the board requested a ruling from the state society on whether this could be considered abandonment. The Liaison Committee replied that there was no legal ruling on this matter but that each case should be decided on its own merits. The board was also informed that the Carroll County Medical Society has established a policy that a physician must provide coverage in his absence but the president of that society stated that this was becoming increasingly difficult to enforce. After some discussion, the board agreed that the society should not attempt to establish a policy on this matter at this time.

The board approved the 1971 budget as presented by the treasurer, Richard L. London, MD. Copies of the budget are available from the society office.

At previous meetings, the board had discussed the operation and organization of the "People's Free Medical Clinic." A letter had been written to C. Lee Randol, MD, one of the physicians working in this clinic, requesting his comments on an article which had appeared in the clinic's July 13, 1970 newsletter. This article stated that the clinic aims to build a community organization that controls the clinic and fights the hidden but powerful medical and hospital power structures of the city. The board felt that this suggested an antisocial nature in the organizations backing the clinic.

Dr. Randol replied that the clinic would like the

backing of the society and the opinions expressed in the newsletter did not necessarily reflect those held by the physicians operating the clinic. However, the board agreed that it would be extremely difficult for the public to discern that the organizations publishing the newsletter (the official communication medium for the clinic) were not expressing the views of all persons concerned with the operation of the clinic. Therefore, it was agreed that at this time the society should not support this clinic.

Philip Whittlesey, MD, has accepted the appointment as chairman of the Peer Review Committee for the society and Anderson Renick, MD, has agreed to serve on the committee. It was reiterated that this will probably become one of the most important functions of the society and that it should be operated in the most efficient and informed manner as possible.

A discussion was held concerning how members are transferred from associate status to active status. Presently, an associate member must complete an application form and be elected a new member of the society. After much discussion, the board agreed that this provided a safeguard to the Membership Committee and the present policy should be continued.

The Ad Hoc Committee to investigate the Maryland Artificial Kidney Treatment Fund submitted its final report to the board. It stated that there were some actions of the physician who operates the fund which seemed questionable and suggested that the matter be referred to the Med-Chi Mediation Committee for consideration. The board concurred in this opinion.

After a brief discussion with Timothy D. Baker, MD, chairman of the Medical Care Committee, the



board approved the following motion submitted by the committee:

"In view of the obvious necessity for containing medical care costs; for conserving hospital and skilled nursing home space; for making optimum use of highly trained medical manpower which is in short supply, the Baltimore City Medical Society supports the formation and adequate funding of home care services programs. Such programs would allow many patients now cared for in hospitals or skilled nursing homes to receive better, more efficient, and less expensive care in their own homes through the proper usage of medical and paramedical personnel.

The Medical Care Committee of the Baltimore City Medical Society offers its assistance in organizing such home care programs; in developing plans for proper funding mechanisms; and in educating both physicians and the public in their use."

Robert E. Farber, MD, informed the board that the governor has stated that there will be a rise in the fees paid by Medicaid. Plans are being made to include funds in the 1971 state budget to allow for payment in full of the usual and customary fees of physicians in the Medicaid program.

There being no further business, the meeting was adjourned at 6 PM.

\* \* \*

The Board of Directors' final meeting of the year was called to order by the president, John N. Classen, MD, at 4:30 PM on December 1.

The minutes of the November 10 meeting were approved as distributed.

A letter received from the AMA regarding recruitment of interns and residents of local hospitals to join the medical society was discussed. While considering this, the suggestion was made that since there are many members on the faculties of both Hopkins and the University of Maryland who are not members of the society, it might be more worthwhile to bring these men into the membership first. It is becoming increasingly evident that all segments of the medical profession must join together to resolve the numerous problems facing the community. Therefore, it was agreed that the president of the society should write to the deans of the medical schools asking their assistance in urging the members of their faculties to join the society.

The annual reports of committee chairmen and representatives were distributed to and accepted by the board. Copies of these reports will be available at the annual meeting of the society or from the society office on request.

Philip Whittlesey, MD, was present for a discussion of the peer review program to be established in the city. An outline of the present activities of the State Peer Review Committee was given and it was agreed that no definite charge could be given to Dr. Whittlesey by the board. The committee should

concern itself with standards of medical care in the community as well as consider any cases of alleged abuse of third-party payors which might come to its attention. It should also be the responsibility of this committee to educate both the physician and the patient on the needs and value of peer review.

Dr. Whittlesey offered considerable insight into the problems confronting peer review. This committee should function efficiently under his leadership.

Timothy D. Baker, MD, presented the following resolution to the board which received approval. This resolution will be presented at the December 3 meeting of the society and acted on at the January 7 meeting.

"There is an obvious need for controlling medical care costs, conserving hospital and skilled nursing home resources, making optimum use of scarce, highly-trained medical manpower.

Many patients now cared for in hospitals or skilled nursing homes could receive less expensive, more appropriate care in their own homes through a well planned, well administered home care service.

In Baltimore there is inadequate private and governmental financing to encourage development of comprehensive home care service.

Therefore, be it Resolved, That the Baltimore City Medical Society urges the formation of home health care services program in this area; and be it further,

Resolved, That the Baltimore City Medical Society requests that since many Blue Cross plans throughout the country now offer home care services coverage to their subscribers, that the Maryland Hospital Services, Inc. work with the medical profession to formulate a plan for home care services for its subscribers; and be it further,

Resolved, That the Baltimore City Medical Society request local, state and federal legislators to hold open hearings in the Baltimore area to investigate the needs for home health care and find methods for financing such a program under Medicaid and Medicare."

There being no further business, the meeting was adjourned at 6 PM.

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# Now that there's a greater therapeutic potential for treating Parkinson's disease and syndrome

*...the information on these pages will be of practical interest to you*

## **Larodopa® (levodopa) Roche : therapy that demands slow, individualized dosage titration**

With the advent of new Larodopa (levodopa), there is now an agent that holds promise of relief of all the major symptoms of Parkinson's disease and syndrome—rigidity and akinesia as well as tremor.

However, as has been reported in the medical literature, levodopa demands slow, careful titration of dosage, and frequent patient monitoring. Adverse reactions may occur at any time, some serious enough to require dosage reduction or discontinuance of therapy. Thus, before prescribing, it is particularly important to refer to the following Important Therapeutic Considerations, the sections covering dosage and administration, and to the information on monitoring the patient (see prescribing information).

### **Important Therapeutic Considerations**

Larodopa (levodopa) is an unusual drug which must be administered with particular care. In view of its high incidence of adverse reactions, you will find the following therapeutic considerations for Larodopa important:

- (a) Larodopa is not curative and its mechanism of action is unknown, though postulated.
- (b) Long-term safety and efficacy for Larodopa have not been established.
- (c) Accurate diagnosis is imperative since there is no evidence that Larodopa is effective in neurological diseases other than Parkinson's disease and syndrome.
- (d) About one-third of patients or more will not experience clinical improvement on Larodopa, and virtually 100% of patients will experience side effects of some degree.
- (e) The dose of Larodopa producing maximal improvement with tolerated side effects must be *carefully titrated for the individual patient*.
- (f) Finally, there is no evidence that early treatment with Larodopa, while possibly controlling symptomatology, alters the course of the disease.



*Photographs of patients treated with Larodopa by permission of the patients.*

### **Guide to dosage and administration of Larodopa® (levodopa) Roche**

*Usual daily dosage*—initially, 0.5 to 1 Gm daily (divided in 2 or more doses with food).

*Total daily dosage*—increased gradually in increments of 0.125 to 0.75 Gm every 2 or 3 days, as tolerated.

*Usual daily dose range*—from 4 to 6 Gm given orally in 3 or more divided doses, with food.

*Daily dosage should NOT exceed 8 Gm.*

*Optimal therapeutic dosage*—usually reached in 6 to 8 weeks.

*Establishing optimal dosage*—must be determined and *carefully titrated for the individual*—gradually increase dosage until: (1) maximal response is seen, or (2) maximum recommended dosage is reached, or (3) side effects preclude further dosage increase, or require reduction or discontinuation of dosage.

*Interrupted therapy*—after brief interruption, dosage should again be adjusted gradually. (In many cases, the patient can be rapidly titrated to his previous therapeutic dosage. See "Precautions" section of Complete Prescribing Information.)

*To underscore the extreme importance of careful dosage titration*, the following week-by-week dosage pattern has been prepared, based on the assumption that the course of therapy is uninterrupted by any complications requiring a change in dosage. (Again, dosage must be reduced when intolerable side effects occur.)

Because it is absolutely imperative that Larodopa therapy be individualized to meet the particular needs of each patient, the following dosage schedule should be considered only a model.





# Larodopa®

## levodopa/Roche

### Titration of Larodopa (levodopa) dosage in a patient evaluated weekly

Intervals	0.25 Gm Tablets	0.5 Gm Tablets	Total Daily Dose
Week 1	½ tab (0.125 Gm) q.i.d. w/ food		0.5 Gm
Week 2	1 tab (0.25 Gm) q.i.d. w/ food		1.0 Gm
Week 3	1½ tab (0.375 Gm) q.i.d. w/ food		1.5 Gm
Week 4		1 tab (0.5 Gm) q.i.d. w/ food	2.0 Gm
Week 5		1½ tab (0.750 Gm) at breakfast and dinner. 1 tab (0.5 Gm) at lunch and bedtime	2.5 Gm
Week 6		1½ tab (0.750 Gm) q.i.d. w/ food	3.0 Gm
Week 7		2 tab (1.0 Gm) at breakfast and dinner. 1½ tab (0.750 Gm) at lunch and bedtime	3.5 Gm
Week 8		2 tab (1.0 Gm) q.i.d. w/ food	4.0 Gm

The daily maintenance dosage in the above example may be increased, decreased, or maintained at the 4 Gm level depending upon the point at which optimal therapeutic results are achieved.

**Concomitant therapies:** Larodopa (levodopa) may be used concomitantly with other antiparkinsonism drugs such as entropine mesylate (Cogentin), trihexyphenidyl HCl (Artane) or procyclidine HCl (Kemadrin), but when more than one drug is used, the usual dose of each may have to be reduced.

**Not to be given concomitantly:** MAO inhibitors. Such agents must be discontinued two weeks prior to initiating Larodopa therapy.

**Note of caution for patients who require vitamin supplementation:** It has been reported that pyridoxine HCl (vitamin B<sub>6</sub>) can rapidly reverse the antiparkinson effects of levodopa therapy.

### timetable for monitoring

While it cannot be emphasized too strongly that each patient on Larodopa must be treated as a totally *distinct* entity, the following are suggested as guidelines in the monitoring of such patients.

**For the first month, at least:** the average ambulatory patient should be seen and evaluated a minimum of *once* week.

**During the second month:** patient evaluations can be extended to *every two weeks* (assuming no laboratory abnormalities or intolerable side effects have occurred).

**3. From the third through the sixth month:** the patient should be evaluated *once a month*.

**4. After six months on the appropriate maintenance dose:** with no significant adverse reactions or laboratory abnormalities, the patient should be seen at least *once every two months*.

**5. Finally, after one year on maintenance dosage:** evaluation should be made no less than *once every three months*.

### Therapeutic response

A favorable response may often be seen within 10 days to several weeks. However, a patient should not be taken off a tolerable dose—even in the absence of a response—until six months have elapsed. This is because, in some instances, the response may come relatively late. Of course, any serious laboratory abnormalities or intolerable side effects automatically dictate discontinuance of therapy.

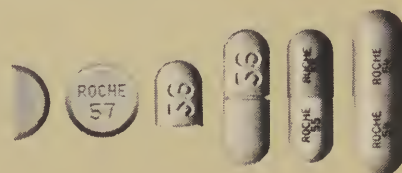
### Lessening the side-effects problem

While it is generally advisable that levodopa be taken after meals, nausea and vomiting, two frequently occurring side effects of levodopa, can often be minimized by taking medication with foods. If nausea becomes intolerable, the dosage should be cut back in daily decrements equal to the most recent increments given the patient. This reduction is to be spaced over two- or three-day intervals. Conversely, as nausea subsides, the drug dosage should be slowly increased in like increments.

An important part of the routine monitoring procedure would be to determine any possible cardiovascular problems. If cardiac arrhythmias occur, Larodopa should be discontinued and other antiparkinson therapy instituted. With orthostatic hypotension a possibility, checking the patient's blood pressure (both supine and standing) is essential.

If choreiform movements appear, they usually occur when maximum therapeutic dosages are reached. To control such effects, reduce dosage by decrements of 0.5 Gm daily.

### Flexible dosage: scored tablets of 0.25 Gm and 0.5 Gm help simplify dosage titration



Conveniently scored 0.25 and 0.5 Gm tablets make possible more precise titration. Should another dosage form be preferred, Larodopa is also supplied in capsule strengths of 0.25 and 0.5 Gm.

**Before prescribing, please consult product information on next page. —>**



*For the relief of symptoms associated with  
Parkinson's disease and syndrome*

# Larodopa® levodopa/Roche

Before prescribing, please consult complete product information, a summary of which follows:

BECAUSE OF THE HIGH INCIDENCE OF ADVERSE REACTIONS AND THE NECESSITY FOR INDIVIDUALIZING THERAPY, THE PHYSICIAN SHOULD THOROUGHLY FAMILIARIZE HIMSELF WITH THE INFORMATION IN THE PACKAGE INSERT BEFORE INSTITUTING THERAPY WITH LARODOPA (LEVODOPA). ACCURATE DIAGNOSIS IS IMPERATIVE BECAUSE EVIDENCE IS LACKING THAT LARODOPA IS EFFECTIVE IN NEUROLOGICAL DISEASES OTHER THAN PARKINSON'S DISEASE AND SYNDROME.

ADEQUATE CLINICAL AND LABORATORY FACILITIES SHOULD BE AVAILABLE FOR PROPER MONITORING OF TREATMENT.

THE LONG-TERM SAFETY AND EFFICACY OF LARODOPA HAVE NOT BEEN ESTABLISHED.

**Indications:** For the treatment of Parkinson's disease and syndrome. Useful in relieving many of the symptoms, particularly rigidity and bradykinesia; frequently helpful in management of associated tremor, dysphagia, sialorrhea and postural instability.

**Contraindications:** In patients for whom a sympathomimetic amine is contraindicated; in patients receiving MAO inhibitors (the latter should be discontinued two weeks prior to initiating therapy with Larodopa); in patients with clinical or laboratory evidence of uncompensated endocrine, renal, hepatic, cardiovascular or pulmonary disease; with narrow angle glaucoma and blood dyscrasias; in patients with known hypersensitivity to levodopa.

**Warnings:** Long-term safety and efficacy not established. Administer with extreme caution to patients with bronchial asthma or emphysema who may require sympathomimetic drugs; to those with active peptic ulcer (in facilities equipped to treat gastrointestinal hemorrhage); in patients with psychoses or severe psychoneuroses. Initiate therapy with extreme caution and in proper treatment facility in patients with a history of myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Monitor all patients for development of mental changes, depression with suicidal tendencies, other serious antisocial behavior. Carefully consider concomitant administration of pyridoxine hydrochloride (vitamin B<sub>6</sub>); oral doses of 10 to 25 mg have been reported to rapidly reverse the antiparkinson effects of Larodopa. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

**Precautions:** During extended therapy, periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended. In diabetic patients, control may be adversely affected; careful, frequent monitoring and proper adjustment of antidiabetic regimen required. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and patient is monitored carefully. Monitor carefully patients receiving antihypertensive agents or psychoactive drugs concomitantly, or those with history of convulsions. If general anesthesia is required, dis-

continue Larodopa 24 hours prior to surgery; monitor cardio-respiratory functions carefully. Patients who improve on Larodopa therapy should resume normal activities cautiously. May be used concomitantly with other antiparkinson drugs with possible reduction in dosage of each.

**Adverse Reactions:** *Most frequently occurring:* nausea, anorexia, emesis, cardiac irregularities, orthostatic hypotension; choreiform, dystonic and other adventitious movements; dizziness, sedation, dyskinesia; psychiatric symptoms such as agitation, anxiety, confusion, depression, hallucinations, delusions, insomnia, nightmares, and mental changes including paranoid ideation and psychotic episodes. *Less frequently occurring* and listed according to system: *psychiatric*—suicidal tendencies, increased libido with serious antisocial behavior, euphoria, lethargy, stimulation, fatigue and malaise, dementia; *neurological*—ataxia, convulsions, faintness, impairment of gait, headache, increased hand tremor, akinetic episodes, torticollis, trismus, oculogyric crisis, weakness, numbness, bruxism; *gastrointestinal*—constipation, diarrhea, epigastric and abdominal distress and pain, flatulence, eructation, hiccups, sialorrhea, difficulty in swallowing, bitter taste, dry mouth, tightness of mouth, lips or tongue, duodenal ulcer, gastrointestinal bleeding, burning sensation of the tongue; *cardiovascular*—nonspecific ECG changes, palpitations, hypertension, flushing, phlebitis; *hematological*—hemolytic anemia (1 case); *dermatological*—sweating, edema, hair loss, pallor, rash, bad odor; *musculoskeletal*—low back pain, muscle spasm and twitching, blepharospasm, musculoskeletal pain; *respiratory*—feeling of pressure in the chest, cough, hoarseness, bizarre breathing pattern, postnasal drip; *urogenital*—urinary frequency, retention, incontinence, hematuria, nocturia, and one report of interstitial nephritis; *special senses*—blurred vision, diplopia, dilated pupils, activation of latent Horner's syndrome; *other*—fever, hot flashes, weight gain or weight loss.

Nausea, anorexia and vomiting usually obviated by temporary dosage reduction and/or administration with food. If cardiac arrhythmias occur, discontinue and institute other antiparkinson therapy. Reduce dosage when involuntary movements occur.

The following have been noted: elevation of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; rarely, positive Coombs test; dark sweat and urine.

**Dosage and Administration:** Because of the strong possibility of adverse reactions and the necessity for individualizing therapy, the physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

**How Supplied:** *Tablets*, pink, scored, containing 0.25 Gm levodopa (imprinted Roche 57) or 0.5 Gm levodopa (imprinted Roche 56)—bottles of 100 and 500.

*Capsules*, containing 0.25 Gm levodopa (pink and beige, imprinted Roche 55) or 0.5 Gm levodopa (pink, imprinted Roche 54)—bottles of 100 and 500.

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MRS. ROBERT W. GARIS, EDITOR

## woman's auxiliary

### Letter from the Ladies

Dear Doctor:

Have you wondered why your dinner is late, why the button is still off your favorite shirt, or why that little lady of yours generally seems to be racing to catch up with her schedule? It just might be because she is one of the "involved" generation of physicians' wives who take seriously the commitment of the Woman's Auxiliary to the Medical Society to participate in community service.

Community service is really the purpose behind all auxiliary endeavors. Since the productivity of a community can be measured by its health, auxiliaries are activated to assist the medical profession in attaining the best possible health for the community. Component auxiliaries throughout the states are involved in a variety of programs which in many instances team them with other health organizations.

During Community Health Week, proclaimed in Maryland by Governor Mandel for October 18 to 24, 1970, ladies of the auxiliary focused public attention on the dramatic advances which have occurred in medicine and health care. They might have been found teamed with heart, TB, eye, dental, and other health organizations in staging a health fair for the community, or making arrangements for an immunization clinic. Now this means that your wife might have been doing anything from personally delivering press releases to every news outlet within a day's ride to driving nails to hold the fair booths together.

One of the important aspects of the community health service is to promote fitness. People need health education, and the auxiliary can provide material to educate them. One such educational thrust might concern physical fitness. This would include such areas as proper exercise and proper nutrition, as well as the all-important regular check-

up. Methods of increasing community awareness of physical fitness possibilities include the presentation of AMA packaged programs (on smoking, alcohol, and drug abuse, for example) to civic groups, PTAs, schools, and clubs.

Your wife might be found pressuring the recreation department to set up bike trails or, on the other hand, pressuring the citizenry to make use of them. "Mrs. Dr." might seek the cooperation of the extension services of the local gas and electric companies for low cost nutritionally balanced menus. With the menus in hand, she may then seek the cooperation of the local editor in having them printed in the daily news.

Another program to which the auxiliary strives to educate the public is the blood donor program. We undertake to emphasize the need for the program (one person in every 80 in the nation will need a transfusion this year). Your wife might donate blood herself, and try to get you to do it too. She might encourage her friends to join a blood bank, or perhaps be on duty to ask prospective fathers to give blood while they are waiting at the hospital.

Other areas for community service are health careers recruitment, transportation pool service for patients who need daily cobalt treatment, and the organization of community seminars on environmental pollution. (Are you using only white kleenex in your office?)

If your dinner has been on time every day this month, and your socks are all darned, perhaps you had better have your wife get in touch with Mrs. Roger Windsor, Chairman of the Auxiliary Community Health Service for the State of Maryland. We can find lots of work for her to do.

Mrs. John Umhau



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**THE FACE IN GENETIC DISORDERS**, Richard M. Goodman, MD, and Robert J. Gorlin, DDS; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This book is dedicated to Victor A. McKusick, MD, of Baltimore, "for his many contributions and unending devotion to medical genetics. . ." The atlas was conceived and developed with three purposes: (1) to create an awareness of the many new genetic syndromes; (2) to improve the diagnostic acumen of those individuals who care for patients; and (3) to stimulate research regarding the basic defect in each disorder in the hope of reaching the ultimate goal of helping the patient.

It has accomplished all of these things if all of those physicians who see patients for diagnosis read it.

Besides containing a fairly large collection of illustrations, it also contains a short text on "basic introductions" involved in examinations and counseling in this field.

**THE EARLY ORTHOPEDIC SURGEONS OF AMERICA**, Alfred Rives Shands, Jr., MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

Dr. Shands, a distinguished orthopedist himself, has taken on the task of selecting some of the outstanding orthopedists in the early years of the development of orthopedic surgery, and writing their accomplishments and their contributions to this specialty.

His selection of men for this distinction is certainly one that shows his wisdom and knowledge of this area. He attributes to some of those chosen not only the introduction of new techniques but also some other notable firsts, such as the establishment of the present *JAMA* (the Journal of the American Medical Association).



**HERNIA REPAIR WITHOUT DISABILITY,** Irving L. Lichtenstein, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

The review of this publication can best be expressed by taking specific sections from its preface. By so doing, it explains more cogently than can be done otherwise the contents and concepts enumerated in it.

"Encyclopedias of hernia surgery have been published. This monograph is not meant to replace them. The text is intended to confront the controversial problems in this field (thus such areas as the treatment of infant hernia are not discussed); polemic concepts and pragmatic answers are presented. Without an explicit stand and an itemization of the facts supporting that position, distillation of this confusing subject is impossible. Only a precise definition of the riddle and its solution will allow critical evaluation.

"The book is in the form of an atlas in order to facilitate comprehension of each step of the operation. The artist's renditions, painstakingly consummated over a period of years, will enable other physicians to utilize this technique with confidence."

**THE IMMUNOLOGY OF MALIGNANT DISEASE,** Jules E. Harris, MD, and Joseph G. Sinkovics, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

Clinicians who are concerned with the management of malignant disease should be particularly interested in this publication. It offers physicians a useful introduction to ideas and methods that will have increasing relevance to the investigation and treatment of cancer in man.

The final section of the book is devoted to the variety of immunotherapeutic approaches to the treatment of malignancies. The theoretical approach, however, is dealt with throughout the entire publication.

**A SYNOPSIS OF PHARMACOLOGY,** V. C. Sutherland, PhD; The W. B. Saunders Company, Philadelphia, Pennsylvania, 1970.

This second edition of this publication has been prepared to meet the needs of all students in the health professions taking an introductory course in pharmacology. It is also useful for review purposes for advanced students and clinicians.

The book is much larger than the first edition, because of an expansion of certain chapters and the inclusion of new chapters on physiology and pathology.

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# ART AND HOBBY EXHIBIT

## Annual Meeting of the Medical and Chirurgical Faculty

### MAY 12, 13, 14, 1971      Baltimore Civic Center

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#### APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....
  2. Amount of space required—depth, width, and height: .....
  3. Electrical or other requirements: .....
  4. Name of exhibitor: .....  
Please print
  5. Address of exhibitor: .....
  6. Telephone number of exhibitor: .....
- 

An Art and Hobby Exhibit will be held during the 173rd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to the Baltimore Civic Center, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, May 11, 1971. They must be removed on Friday, May 14, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.

A Hobby Corner at the Semiannual Meeting of the Faculty in Hershey created a great deal of interest. LET'S MAKE IT A REAL "SHOW" FOR THE 1971 ANNUAL MEETING. SUBMIT YOUR ENTRIES NOW!





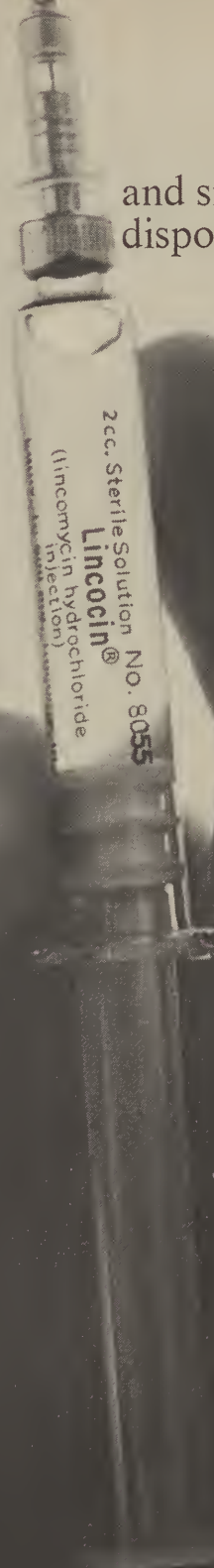
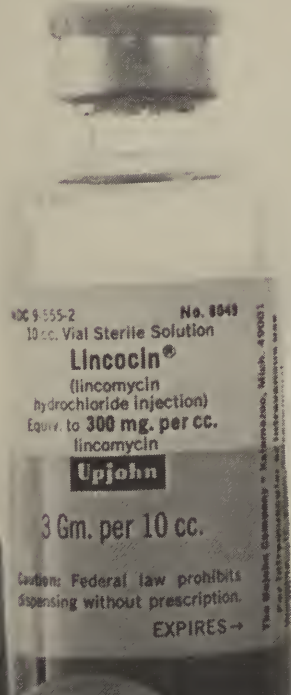
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Assistant Professor of Pediatrics

Johns Hopkins University School of Medicine

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Replays: Monday, January 25, 1971	12:30 PM
Wednesday, January 27, 1971	7:30 AM
	9:00 AM
	2:00 PM

**JANUARY 29, 1971 — 12:30 PM**

## **ALTERATION OF THE HORMONAL MILIEU IN THE MANAGEMENT OF ADVANCED BREAST CANCER**

**John H. Mather, MD**

Department of Surgery

University of Maryland School of Medicine

**Sponsor: PENINSULA GENERAL HOSPITAL**

Replays: Monday, February 1, 1971	12:30 PM
Wednesday, February 3, 1971	7:30 AM
	9:00 AM
	2:00 PM

**FEBRUARY 3, 1971 — 8:00 PM**

## **MANAGEMENT OF U.T.I.**

**Patricia Charache, MD**

Assistant Professor of Medicine

Johns Hopkins University School of Medicine

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Replays: Friday, February 5, 1971	12:30 PM
Monday, February 8, 1971	12:30 PM
Wednesday, February 10, 1971	7:30 AM
	9:00 AM
	2:00 PM

**FEBRUARY 12, 1971 — 12:30 PM**

## **FAMILY INTERACTION IN ILLNESS**

**Frank T. Rafferty, MD**

Professor of Psychiatry and Director

Division of Child Psychiatry

University of Maryland School of Medicine

**Sponsor: ST. AGNES HOSPITAL**

Replays: Monday, February 15, 1971	12:30 PM
Wednesday, February 17, 1971	7:30 AM
	9:00 AM
	2:00 PM

**FEBRUARY 19, 1971 — 12:30 PM**

## **ACUTE MUSCULOSKELETAL TRAUMA**

**Thomas A. Otter, MD**

Assistant Resident in Orthopedic Surgery

Johns Hopkins University School of Medicine

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Replays: Monday, February 22, 1971	12:30 PM
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**SATURDAY MORNINGS — 10:00 AM**

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## MEDIC . . .

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**For further information contact:**

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**SPECIFICATIONS:** Manuscripts must be original typed copy, doublespaced throughout (including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

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Be sure that statistics are consistent in both tables and text.

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All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article,

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**ILLUSTRATIONS:** Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

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Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

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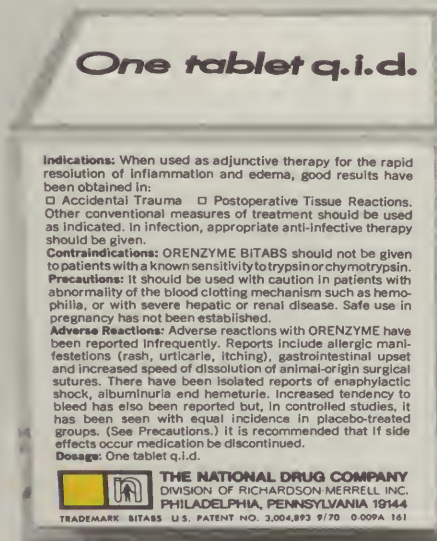
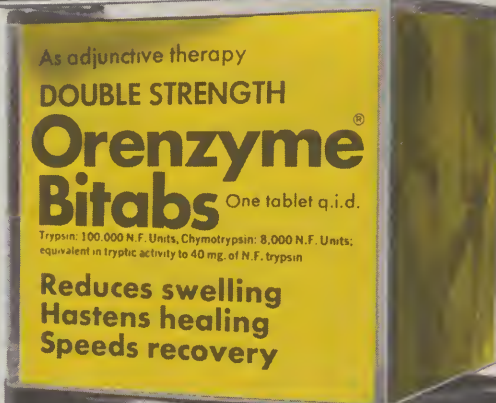
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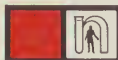
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- Transportation of the Injured and Acutely Ill**
- Operation of Emergency Rooms**
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- Masked Emergencies**
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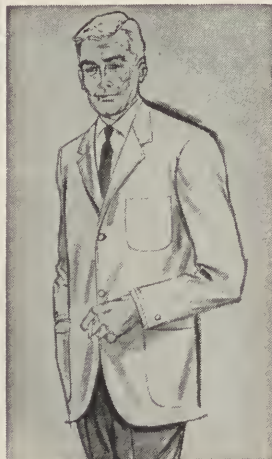


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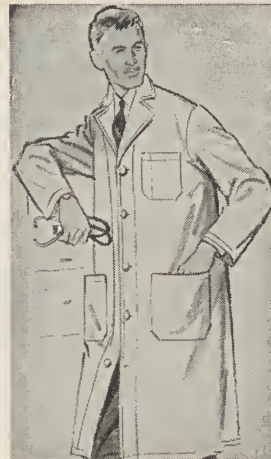
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## 173rd ANNUAL MEETING

of the

Medical and Chirurgical Faculty of Maryland

MAY 12, 13, 14, 1971

BALTIMORE CIVIC CENTER, BALTIMORE, MARYLAND

Presenting papers during the Annual Meeting will be:

**Alan F. Guttmacher, MD**

President  
Planned Parenthood-World Population  
The Hundley Memorial Lecture in Gynecology

**G. Rainey Williams, MD**

Professor of Surgery and Chairman  
Department of Surgery  
University of Oklahoma Medical Center  
The J. M. T. Finney Fund Lecture

**George E. Schreiner, MD**

Director of Nephrology Division  
Department of Medicine  
Georgetown University School of Medicine  
The Albert E. Goldstein Memorial Lecture

**Saul Krugman, MD**

Professor and Chairman  
Department of Pediatrics  
New York University  
Harvey Grant Beck Memorial Lecture

**Lawrence K. Pickett, MD**

Professor of Pediatric Surgery and Pediatrics  
Yale University School of Medicine  
The I. Ridgeway Trimble Fund Lecture

**Nicholas J. Pisacano, MD**

Secretary  
American Board of Family Practice, Inc.  
University of Kentucky Medical Center  
The George M. Boyer, MD, Lecture

**Edward C. Rosenow, Jr., MD**

Executive Director  
American College of Physicians  
The Amos R. Koontz Memorial Lecture

**Neil L. Chayet, Esquire**

Boston, Massachusetts  
The Jesse C. Coggins Fund Lecture



**MEDICAL PEDIATRIC GRAND ROUNDS**, conducted by Marvin Cornblath, MD, Professor and Head, Department of Pediatrics, University of Maryland School of Medicine, will follow the talk given by Saul Krugman, MD, on Thursday morning, May 13.

**SURGICAL PEDIATRIC GRAND ROUNDS**, conducted by J. Alex Haller, Jr., MD, Robert Garrett Professor of Pediatric Surgery, The Johns Hopkins University School of Medicine, will follow the talk given by Lawrence K. Pickett, MD, on Thursday afternoon, May 13.

**PANEL-SYMPOSIUM** on *Treatment of the Alcoholic and the Family: Practical Aspects*, conducted by Martin L. Singewald, MD, Chairman of the Committee on Medicine and Religion of the Medical and Chirurgical Faculty, has been scheduled for Wednesday evening, May 12.

#### SCIENTIFIC AND TECHNICAL EXHIBITS

Many exhibits, both technical and scientific, will be on display at the Baltimore Civic Center all during the Annual Meeting. **SEE THESE EXHIBITS AND KEEP ABREAST OF SCIENTIFIC ADVANCEMENT!**

All physicians who have a scientific exhibit are invited to submit an application. See page 54 of this Journal for the form.

#### OTHER ANNUAL MEETING ACTIVITIES

**ROUND TABLE LUNCHEON**—catered at the Baltimore Civic Center.  
Various subjects of interest to all physicians will be discussed.

**HOSPITALITY NIGHT** at the Baltimore Hilton Hotel. A fun function for all!

**PRESIDENTIAL RECEPTION AND BANQUET**—a dinner dance at the Blue Crest North.  
This will be an affair long to be remembered by all who attend.

**ART AND HOBBY EXHIBIT** at the Baltimore Civic Center. All physicians, their wives, and families are invited to complete and send to the Faculty office the application on page 28 of this Journal.

**BUSINESS MEETINGS**—Wednesday morning, May 12, and Friday afternoon, May 14.

**MORE DETAILS LATER —**

**BUT MARK THESE DATES ON YOUR CALENDAR NOW**

**MAY 12, 13, 14, 1971**

Arlie R. Mansberger, Jr., MD, *Chairman*  
Committee on Program and Arrangements



# ABOUT THE SPEAKERS

## for the Faculty's

### 173rd ANNUAL MEETING



**Dr. Guttmacher**

**Alan F. Guttmacher, MD**, President of Planned Parenthood-World Population (Planned Parenthood Federation of America, Inc.), will give the annual Hundley Memorial Lecture in Gynecology on **WEDNESDAY AFTERNOON, MAY 12**. Dr. Guttmacher is a diplomate in Obstetrics and Gynecology, a member of the faculty of the Albert Einstein School of Medicine, and Emeritus Professor of Obstetrics and Gynecology at New York's Mount Sinai School of Medicine. Until 1966 he was Clinical Professor at Columbia's College of Physicians and Surgeons and lecturer at the Harvard School of Public Health. He is the author of many scientific and popular books and articles on contraception, infertility, pregnancy, twinning, and the history of medicine.

A native of Baltimore and a graduate of The Johns Hopkins University School of Medicine, Dr. Guttmacher taught anatomy at his alma mater and at the University of Rochester. After residency training, he became Associate Professor of Obstetrics at Hopkins. Later, he became Director of the combined Department of Obstetrics and Gynecology at New York's Mount Sinai Hospital, a post he held until 1962 when he assumed leadership of Planned Parenthood-World Population, the U.S. national voluntary birth control organization. He is Past-President of the New York Obstetrical Society and former Chairman of the Central Medical Committee of International Planned Parenthood Federation in London.

**Edward C. Rosenow, Jr., MD**, the Executive Director of the American College of Physicians, is one of a special breed of administrative physicians—the MD executive who likes to keep in touch with clinical medicine. Dr. Rosenow, who practiced internal medicine for 17 years before becoming the ACP's Executive Director in 1960, is Adjunct Clinical Professor of Medicine at the University of Pennsylvania. Among the ways he keeps in touch with the practice of medicine is to teach on the



**Dr. Rosenow**

University of Pennsylvania's services at Philadelphia General Hospital and Pennsylvania Hospital.

Dr. Rosenow serves his specialty as a member of the Joint Commission on Accreditation of Hospitals, the AMA Residency Review Committee in Internal Medicine, the Council of Medical Specialty Societies, and the Commission on Professional and Hospital Activities. All of these organizations are involved in improving the standards of medical practice. He is also Chairman of the AMA Advisory Committee on Continuing Education and is on the advisory committee for CARE-MEDICO, an international medical services organization.

Playing such an active role in the many facets of his career has been a habit with this executive director since his graduation from Carleton College in Northfield, Minnesota. He received his medical degree from Harvard Medical School and went on to the Mayo Clinic where he fulfilled his residency requirements in internal medicine. His father, the late Edward Carl Rosenow, Sr., MD, was a distinguished physician-bacteriologist on the clinic's original staff.

While at Mayo, Dr. Rosenow received a Master of Science in Medicine degree from the University of Minnesota (Mayo Foundation). His formal education completed, he moved to Pasadena, California to begin nearly two decades of private practice. He taught at the University of Southern California School of Medicine, attaining the position of Clinical Professor of Medicine. From 1951 to 1959, Dr. Rosenow was Chairman of the Postgraduate Activities Committee of the California Medical Association and became Editor-in-Chief of *Audio Digest*, a nonprofit subsidiary of the association in 1954.

Dr. Rosenow retired in 1957 from active practice to become Executive Director of the Los Angeles County Medical Association, a position he held until moving to the American College of Physicians. He is a Fellow of the American College of Physicians, the Royal College of Physicians of London, and the College of Physicians of Philadelphia, and a Diplomate of the American Board of Internal Medicine. Among the many honors and awards he has received are an honorary ScD degree granted in 1967 by Carleton College and the University of Minnesota's Distinguished Alumnus Award in 1965. Dr. Rosenow has written and published numerous papers.

On **FRIDAY MORNING, MAY 14**, Dr. Rosenow will give the Amos R. Koontz, MD, Memorial Lecture at the Baltimore Civic Center.



As a result of continuing emphasis on local needs, another physician and two new oral surgeons have recently been approved by the Credentials Committee of the Medical Staff of the Washington County Hospital. These three new appointees are:

**Joseph F. Norato, Jr., MD**, a member of the American College of Anesthesiologists, will be administering anesthesia.

**Richard L. Behan, DDS**, has opened his office at 138 East Antietam Street. Dr. Behan held a teaching position at the University of Maryland Dental School.

**Joseph M. Wiesenbaugh, Jr., DDS**, is now associated with Daniel L. Hohman, DDS, at 314 N. Potomac Street. He is a graduate of the University of Maryland Dental School.

\* \* \*

The following Baltimore physicians were recently elected members of the American College of Physicians. They are: **Ronald F. Gillian, MD; Henry R. Herbert, MD; Ramon F. Roig, MD; Elijah Saunders, MD; and Gustav C. Voigt, MD.**

The following physicians have been elected fellows of the ACP: **Raymond D. Bahr, MD; Torrey C. Brown, MD; Howard D. Bronstein, MD; Wilmer K. Gallagher, Jr., MD; John B. Imboden, MD; Raymond E. Lenhard, Jr., MD; Patricia A. McIntyre, MD; Joseph A. Mead, Jr., MD; Joseph S. Redding, MD; R. Patterson Russell, MD; Mary B. Stevens, MD; Alexander S. Townes, MD; Emidio A. Bianco, MD; and A. Austin Pearre, Jr., MD.**

\* \* \*

**Chris Papadopoulos, MD**, Chief of Cardiology at South Baltimore General Hospital, has been elected Chairman of the Medical Staff.

Other newly elected medical staff officers are **Erney Maher**,

## MEDICAL NEWS

**MD**, vice-chairman; and **Cesar Tonder, MD**, secretary-treasurer. Dr. Tonder is associate director of the department of obstetrics and gynecology there and Dr. Maher is director of pediatrics.

\* \* \*

A new booklet, designed to stimulate active participation in the effort to eradicate tuberculosis, is currently receiving widespread distribution throughout the United States.

The 20-page booklet is entitled "**Tomorrow Without TB**", and is being made available to state and school health officers, medical societies, the national headquarters of various civic organizations, and state and local tuberculosis associations.

The booklet was prepared by the Trade Information Services Department at Lederle Laboratories, Pearl River, N.Y. 10965. Single copies are available upon request.

\* \* \*

The Johns Hopkins University School of Medicine has been awarded a \$114,693 grant by the John A. Hartford Foundation, Inc., of New York, to conduct studies on the treatment and prevention of allergic diseases.

**Kimishige Ishizaka, MD**, principal investigator for the project, said that the research program has two main objectives: the development of improved and new methods of treatment of allergies; and the prevention of allergic disease.

\* \* \*

**Harold E. Harrison, MD**, head of the Department of Pediatrics,

Baltimore City Hospitals, recently received the Judith Hochreiter Memorial Award.

The purpose of the award was to honor Dr. Harrison for his devoted and vigorous action on behalf of the health care of foster children in the city of Baltimore.

\* \* \*

**Russell A. Nelson, MD**, president of The Johns Hopkins Hospital, has been named chairman-elect of the Association of American Medical Colleges. It will be the first time that a hospital head will serve as the association's chairman.

\* \* \*

"About Venereal Disease," a 45-frame, sound filmstrip, is available for loan from the State Department of Health and Mental Hygiene. It may be borrowed without charge by contacting Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore. (Phone 383-3010, ext. 8516.)

\* \* \*

Maryland's first regional mental retardation center, and the first brand new facility of its type since 1889, recently opened its doors to full-time residents.

The new institution, **Maryland Metropolitan Washington Mental Retardation Center**, constructed at a cost of \$3,832,000, is located near Silver Spring, south of Route 29 on East Randolph and Cherry Hill Road.

\* \* \*

Members of the American



College of Physicians from four states recently held a three-day meeting in Colonial Williamsburg. Maryland physicians who took part in the program included: **Samuel P. Asper, MD**, immediate past-president of the ACP; **W. R. Bell, MD**; **Turner Bledsoe, MD**; **Gottlieb C. Friesinger, MD**; **Harry F. Klinefelter, MD**; **J. O'Neal Humphries, MD**; **Arnall Patz, MD**; **Thaddeus Prout, MD**; **Martin L. Singewald, MD**; and **Mary B. Stevens, MD**; all of Johns Hopkins.

Also speaking were: **Francis Johnson, MD**; **Patricia Johnson, MD**; and **Peter C. Luchsinger, MD**, all of Good Samaritan Hospital; and **Richard P. Allen, MD**, and **Louise Faillace, MD**, of Baltimore City Hospitals.

Physicians from the University of Maryland Hospital who spoke were: **T. B. Connor, MD**; **H. L. Dupont, MD**; **S. B. Formal, MD**; **Richard B. Hornick, MD**; **J. P. Libonati, MD**; **Buis G. Martin, MD**; and **M. J. Snyder, MD**.

Dr. Singewald, associate professor of medicine at The Johns Hopkins Hospital School of Medicine, is the ACP Governor for Maryland.

\* \* \*

Biomedical engineering has been elevated from a sub-department to full departmental status at The Johns Hopkins Hospital University School of Medicine and The Johns Hopkins Hospital.

Named to head the new department is **Richard J. Johns, MD**, professor of medicine. Dr. Johns, who has been at Hopkins since 1951, has been directing the school's biomedical engineering efforts for the past ten years.

\* \* \*

**Philip Lazaroff, MD**, was recently appointed the Assistant Professor of Psychiatry at The Johns Hopkins University School of Medicine. In addition to his

new post, Dr. Lazaroff will also serve as a child psychiatrist at the Columbia Hospital and Medical Clinic, Columbia, Maryland.

\* \* \*

**Julius R. Krevans, MD**, Dean of Academic Affairs at The Johns Hopkins Medical School, has been appointed dean of the School of Medicine at the University of California's San Francisco campus.

Dr. Krevans has been at The Hopkins since 1950, beginning as a fellow in medicine. He was appointed an instructor in 1953, a professor in 1968, and a dean in 1969. For several years, he was physician-in-chief at Baltimore City Hospitals.

\* \* \*

The **National Academy of Sciences-National Research Council** invites submission of current data on somatic, genetic, and environmental effects of low-level ionizing radiation, including effects on human growth and development. This material is requested whether or not it has been published. Work in progress, which is yet to be reported, is of particular interest.

The request is made in order to assist an advisory committee of the National Research Council in its deliberations concerning ionizing radiation effects on human populations.

Send any material to the Division of Medical Sciences, A. W. Hilberg, MD, the National Advisory of Sciences, 2101 Constitution Ave., Washington, D.C. 20418.

\* \* \*

A guide to nationally established voluntary aid agencies whose work relates to mental health has been issued by the National Institute of Mental Health, Health Services and Mental Health Administration, Department of Health, Education, and Welfare.

Designed to aid the citizen

who is seeking help or information about the organization and delivery of community mental health services, the pamphlet is entitled "The Voluntary Agency and Community Mental Health Services". It lists the major voluntary agencies which provide some type of service related to mental health, and which in many instances are affiliated with mental health centers.

\* \* \*

The **Johns Hopkins University School of Medicine** has received a grant from the Commonwealth Fund, a philanthropic foundation based in New York.

The grant for \$250,000 is for the university-wide program in the development of systems of community health care.

\* \* \*

**Richard D. Rowe, MD**, professor of pediatrics at The Johns Hopkins University School of Medicine, has been named the first Harriet Lane Home Professor of Pediatric Cardiology.

Dr. Rowe, a native of New Zealand, came to Hopkins in 1963. In 1965, he was named director of the pediatric cardiac clinic, which is now the Helen B. Taussig Children's Cardiac Center in the Children's Center of The Johns Hopkins Hospital.

\* \* \*

In November 1970, **Horace Hodes, MD**, delivered the 26th annual Phi Delta Epsilon Lecture of the Baltimore Graduate Club. The lecture, given at the University of Maryland Hospital, was entitled "Endotoxic Shock."

The medical fraternity sponsoring the lecture was founded in 1940 by Dr. Aaron Brown at Cornell Medical School. With well over 20,000 graduate and undergraduate members in chapters in many medical schools throughout the coun-



try, the fraternity sponsors an annual lectureship in most medical schools through its Aaron Brown Educational Foundation.

The club also honored **Samuel S. Glick, MD**, of Baltimore, during its November meeting. A native Baltimorean, Dr. Glick received his MD degree from the University of Maryland School of Medicine in 1925. He is presently Associate Professor of Pediatrics at the University Hospital. Dr. Glick also serves as a pediatrician with the Baltimore City Health Department in the public schools and the well-baby clinics and is vice-president of the educational foundation which sponsors this lectureship.

\* \* \*

**Robert Angle, MD**, Bethesda internist, has been elected the 67th president of the Montgomery County Medical Society, Inc.

Dr. Angle has served on the executive board of the society, and has served as its treasurer and vice-president. He is also a delegate of the Medical and Chirurgical Faculty of the State of Maryland. Dr. Angle also serves on the Medical Council of the Washington Metropolitan Area and will serve through 1972.

\* \* \*

**January is National Blood Donor Month.** President Nixon recently proclaimed it as such at the 23rd meeting of the American Association of Blood Banks held last October.

\* \* \*

Emergency medical care will be improved at the Washington County Hospital according to **Richard A. Young, MD**, chief of the hospital's medical staff. "Although the physician-to-population ratio is still lower than what

we would like, ten new physicians—five in emergency care service and five in general practice—will be added to the medical community and will appreciably improve regular care as well as treatment of emergency cases," said Dr. Young.

Three physicians who will expand local medical resources in Washington County include: **Eldon Leon Hawbaker, MD**, who was trained at Mercy Hospital, University of Maryland Hospital, and Mt. Wilson State Hospital; **John H. Hornbaker, Jr., MD**, who was graduated from The Johns Hopkins University School of Medicine and was trained at the University of Virginia Hospital and Johns Hopkins Hospital; and **John Wesley Wilson, MD**, who was graduated from the University of Maryland Medical School and was trained at the York Hospital.

\* \* \*

At the head of the line signing up for the recent meeting of the Eastern Section of the American Thoracic Society is the president of the Maryland Thoracic Society, **David G. Simpson, MD**. To his right is **William H. Becker, MD**, secretary-treasurer of the Eastern Section, and incoming 1971 president of the Northeast Conference, **Nathan Heiligman, MD**. **Mrs. Ruth Disney**, administrative assistant at the Maryland Tuberculosis and Respiratory Disease Association, registers the physicians on the opening day of the conference, which was held at the Belvedere Hotel in Baltimore. Eleven northeastern states sent representatives to the sessions, which featured many prominent guest speakers.





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**Special note:** Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Demulen is indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>1</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated

after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13: 267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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Rep. Wilbur D. Mills (D., Ark.) expressed concern about claims that prepaid group health care, or health maintenance organizations, could solve most of the problems of medicare and medicaid.

Speaking to a group of business executives, the chairman of the House Ways and Means Committee, which handles medicare and medicaid legislation, said that he believed health maintenance organizations were "a reasonable and perhaps competitive alternative" for providing government-financed health care.

"However," he added, "I have become concerned that we will expect a great deal more from them than is likely to occur. The health industry is too diversified and its problems too complex to ever conclude that any one approach will solve most or all of the problems."

Americans broke a spending record for health care this past year, paying out about \$70 billion for everything from aspirin to hospitals, Mills also said. Inflation accounted for half the boost of about 16% over the \$60.3 billion spent in the previous fiscal year, he said.

Mills said he expects health care spending figures for fiscal 1970, which ended July 1, will show that \$7 out of every \$100 spent in the United States for all goods and services went for health expenditures. "Just three years ago," Mills said, "it was estimated that we could not reach the 7% level until 1975."

He noted, however, that the fiscal 1970 figures would show "for the first time" that federal spending did not increase as fast as private spending for health services.

"The reason for this development is that the medicare program did not grow as fast as it had been growing," Mills said.

Mills said the new health care figures point out two major char-



## THE MONTH IN WASHINGTON

acteristics of the health industry—"rapidly escalating costs and rapidly increasing public involvement."

"Public funds now pay for one half of all the hospital care provided in the country," Mills said. "Medicare and medicaid together account for almost all of the half."

\* \* \*

**National health insurance is shaping up as one of the major domestic issues before the 92nd Congress with catastrophic illness coverage gaining support from both Democrats and Republicans.**

Advocates of catastrophic coverage counted on the Nixon Administration supporting such a plan although Elliot L. Richardson, Secretary of Health, Education, and Welfare, called for its rejection at that time when it unexpectedly was placed before the Senate Finance Committee in executive session late last year near the end of the 91st Congress. But he left the door open for Administration support later.

"A proposal with this impact on the health care system deserves the closest kind of examination, not the hasty look it has been given in the waning days of an executive session," Richardson said.

The secretary's comment was in response to the surprise announcement by Sen. Russell B. Long (D., La.) that he would offer a catastrophic illness cov-

erage plan to the finance committee of which he is chairman.

Long's plan called for the government to pay 80% of all medical costs beyond the first 60 days of hospitalization or the first \$2,000 of physicians' bills for all Americans who pay social security taxes and are under age 65. He estimated the cost at \$2.5 billion a year to be financed by a one-half of one percent increase in social security taxes, to be shared equally by employers and employees.

The American Medical Association also cleared the way to add catastrophic coverage to its Mediredit plan for voluntary national health insurance. The House of Delegates, at the AMA 1970 clinical convention in Boston, approved a report of the Board of Trustees listing catastrophic coverage among the modifications and improvements being considered before reintroduction of the Mediredit legislation.

All national health legislation introduced during 1969-70 died with the final adjournment of the 91st Congress, and some modifications were expected to be incorporated in most of the leading proposals before their reintroduction in the 92nd Congress.

During the final months of the 91st Congress, Rep. Durwood G. Hall (R., Mo.), a physician, introduced legislation that would establish a government program of catastrophic illness insurance for all Americans along



with a program of basic health care protection for the medically indigent.

Part A (Basic Protection) of Hall's proposal would replace the present medicaid program. Each state would be authorized to determine the level of medical indigence in that state and to purchase basic health insurance coverage for the medically indigent from private carriers. The states would receive federal reimbursement for 85% of the costs incurred in providing this basic coverage.

The states would also purchase coverage for the costs of catastrophic illness expenses for the medically indigent. There would be no federal reimbursement for this state coverage.

Part B (Catastrophic Coverage) would have the Secretary of HEW establish a program of insurance against the costs of catastrophic illness. Any U.S. resident whose income is above the level of medical indigence would be entitled to reimbursement for expenses incurred as a result of catastrophic illness. Federal reimbursement would be 90% of total eligible expenses.

Eligible expenses would be those health care costs above whichever of the following is the larger: (a) \$1,000 for those age 65, or \$5,000 in any other case, or (b) 25% of the gross income of the individual or his family.

Funds for this two-part program would be managed by a Federal Health Care Trust Fund. Money for this trust fund would be raised through a 0.4% tax on wages and self-employment income, and on other income in excess of \$2,000 up to the maximum income in use for purposes of the social security tax. There would also be a 0.4% employer tax.

Hall estimates that the Part A would cost the federal government about \$3.7 billion a year. The cost to the states for

Part A would be about \$600,000. Medicaid presently costs the states about \$2.5 billion.

There was no estimate as to the cost of Part B, but Hall said that it would be only a small fraction of the cost of a comprehensive national health insurance program of the type being pushed by organized labor.

"All government efforts to date have been directed at providing first-dollar coverage," Hall said. "Invariably, first-dollar coverage entails high administrative costs, for it requires that many small claims be processed. Thereby, the substance of the program is eroded. My aim is to amend and to protect existing law or substitute therefor so that the public can be insulated from disastrously high costs; give meaningful relief to those hardest hit by extensive medical expenses; make the existing program work easier; and at the same time make the greatest use possible of the dollars available."

\* \* \*

**In the final days of the 91st Congress, Congress approved two important medical bills dealing with family practice and birth control.**

The main feature of the family practice legislation authorized a three-year, \$225 million program to help medical schools establish and operate departments to train family physicians.

The legislation passed the Senate and House with virtually no opposition. It was supported by the American Academy of General Practice and the American Medical Association. The Nixon Administration opposed it, mainly because of its categorical grant character.

Only nine U.S. medical schools already have established departments of family practice, and chief sponsors of the legislation hailed its passage as an

important step toward alleviating the shortage of family physicians and slowing down the trend to specialization in the practice of medicine. It was praised as "a significant step in the efforts of Congress to meet the health crisis facing this nation."

A family planning bill authorizes birth control services, except abortion, for all American women who cannot afford them. The birth control services will include contraceptive drugs and devices, as well as consultations, examination, and instruction.

The legislation also provides for federal aid for birth control research and establishes an Office of Population Affairs in the Department of Health, Education and Welfare.

To finance the program for the first three years, House-Senate conferees agreed on a compromise authorization of \$387 million. The House had approved \$267 million for three years and the Senate, \$967 million for five years.

Expenditure of federal funds for abortion is prohibited.

\* \* \*

**A special panel of Senate consultants urged a multibillion dollar crusade against cancer to erase its "staggering" impact of death and suffering on all mankind.**

In a brief but detailed report to the Senate Labor and Public Welfare Committee on its four-month study of the disease, the 26-member panel estimated that 50 million Americans now living will develop the disease and 34 million of them will die unless immediate steps are taken.

The consultants recommended a sweeping program keyed to consolidation of all existing cancer research projects into a national cancer authority directly responsible to the President.

"The committee is unanimously of the view that the conquest of cancer is a realistic



goal if an effective national program along the lines in the report is promptly initiated and relentlessly pursued," said Benno C. Schmidt, co-chairman of the group.

"Given the seriousness of the cancer problem to the health and morale of our society, this allocation of national priorities seems to be open to serious question," the panel said.

It recommended doubling cancer research spending to \$400 million in the 1972 fiscal year, and increasing it by \$100 mil-

lion to \$150 million in subsequent years to a \$1 billion level in 1976.

The panel said their recommended program "is so important to the American people and to the world" that the money should be spent even if taxes have to be raised to pay the bill.

The panel of consultants, which included labor and civic leaders as well as distinguished cancer researchers, said that the program should be devoted primarily to research into the causes and cures of cancer,

rather than only to patient care.

The panel said that the cost of cancer has been estimated "as high as \$15 billion a year," of which as much as \$5 billion is spent on caring for patients. The balance is in the loss of earning power and productivity.

It said that only 89 cents was spent last year for each man, woman, and child in the United States on cancer research, compared with \$140 per capita on national defense, \$125 for the Vietnam war, and \$19 each on space programs and foreign aid.

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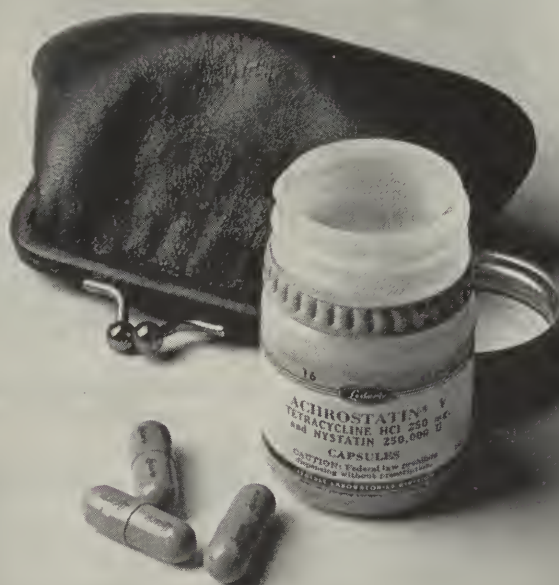
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# American Association of Medical Assistants



Dr. Zimmerman

The AAMA, Baltimore Chapter, conducted a course in Anatomy and Physiology for a period of two months, October through November 1970, with classes held in the Surgical Conference Room at Church Home and Hospital each Monday night. This consisted of a series of lectures, aided by three-dimensional slides and other visual aids and taught by J. M. Zimmerman, MD, and Raymond M. Atkins, MD.

Dr. Zimmerman is Chief of Surgery at Church Home and Hospital and Associate Professor of Surgery at Johns Hopkins University. He has long aided the cause of the medical assistant in Maryland, along with his many, many other interests and endeavors. Dr. Zimmerman has the unique distinction of combining three concurrent careers in one as a practicing surgeon, medical educator, and clinical researcher. Cited in "American Men of Science" and "Who's Who in the East," Dr. Zimmerman has just been awarded the Alumni Achievement Award by the Alumni Association of the University of Missouri-Kansas City where he earned his MA in education after completing his medical education at Johns Hopkins.

Dr. Raymond M. Atkins, general surgeon, is Assistant Director of Medical Education at Church Home and Hospital, Instructor in Clinical Anatomy and Instructor in Surgery at University of Maryland School of Medicine, and Assistant Surgeon, Out-patient Vascular Clinic, Johns Hopkins Hospital.

He has been advisor to the Maryland Chapter of AAMA for the past five years and instituted the first course in Anatomy and Physiology offered by this group to its members and the general public. Dr. Atkins is a Diplomate of the American Board of Surgery, Fellow of the American College of Surgeons, Fellow of the Southeastern Surgical Congress, and member of the Association of Hospital Directors of Medical Education.

These courses, along with others of interest and great assistance to all medical secretaries and clinical assistants, are offered each year by the AAMA free to members and with only a nominal charge to nonmembers of the association. The courses are arranged primarily for the purpose of assisting those persons interested in taking the examination for Certified Medical Assistant given by the national AAMA each year. However, the content is such that it is invaluable in the pursuit of the daily work of all paramedical personnel and is to be highly recommended for all physicians' assistants. All lectures and courses are taught by highly qualified teachers.

For information regarding present and future courses on the subjects of Medical Law, Laboratory Procedures, Sterilization, Accounting, Medical Terminology and Medical Ethics, please contact Mrs. Thelma Dorsett at 235-1790.



Dr. Atkins



## SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 12, 13, 14, 1971

Baltimore Civic Center

More space is available than in former years. However, it is suggested that applications be submitted as soon as possible.

### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO

NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: \_\_\_\_\_

2. Please attach a 50-100 word description of the exhibit: \_\_\_\_\_

3. Give amount of space required, depth, width, and height: \_\_\_\_\_

If exhibit has side panels, are depth and width included above? \_\_\_\_\_

If not, what additional space is required? \_\_\_\_\_

4. Electrical or other requirements: \_\_\_\_\_

5. Has exhibit been shown at other medical meetings? \_\_\_\_\_

6. Name and title of exhibitor: \_\_\_\_\_

7. Name of institution cooperating in the exhibit: \_\_\_\_\_

8. Address of exhibitor: \_\_\_\_\_

SEE RULES GOVERNING SCIENTIFIC EXHIBITS



THE EXHIBITS—A WORTHY FEATURE  
OF THE EDUCATIONAL PROGRAM  
of the  
MEDICAL AND CHIRURGICAL  
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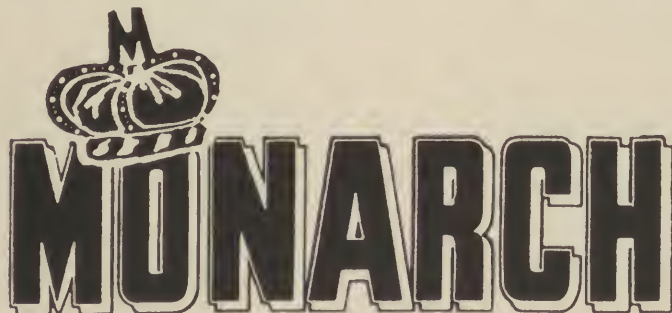


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Ten weeks after discontinuance of  
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In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When new lesions appeared, repeated courses of Efudex therapy proved effective.\*

## Predictable therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, swelling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three weeks before gradually receding. Since this response is predictable, lesions which do not respond should be biopsied.

## Two strengths—two dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings

and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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# Cooperative Blood Replacement Plan

Fifty Chicago-area hemophiliacs have become eligible for \$250 each to defray blood replacement expense from the Cooperative Blood Replacement Plan. The grant was announced recently in a joint statement by Frank E. Trobaugh, Jr., MD, president of the plan, and Robert J. Faust, president, Midwest Chapter, the National Hemophilia Foundation.

According to Dr. Trobaugh, "It has long been the objective of the Cooperative Blood Replacement Plan to assist persons with blood complications such as leukemia and hemophilia. The enrollment of 50 of the 300 midwest area hemophiliacs as special CBRP members is a step in the right direction. But the public's support in becoming members of this program will hasten the time when the CBRP will be able to meet the needs of hemophilia victims."

Of the 50 CBRP grant recipients, seven families have two children and one family has three children who have hemophilia.

In awarding the \$12,500 grant, the Cooperative Blood Replacement Plan stipulated that benefits be extended only to active members of the Hemophilia

Foundation and that each member selected by the foundation be required to have two blood donations made to the CBRP in his name.

Benefits were limited to the first 50 applicants and provide for a maximum of \$250 for blood replacement until June 1, 1971.

The Cooperative Blood Replacement Plan is a non-profit public service program with the objectives of augmenting the available supply of whole blood for transfusion purposes, assisting blood banks, and helping individuals secure blood for possible future blood needs. The plan currently has 57 participating hospitals and blood banks working together to accomplish these objectives.

With a one-pint donation, area residents can supplement the community's blood supply and assure themselves of possible blood needs for four years, or their husband or wife for two years, or their entire family for one year.

For information, write the Cooperative Blood Replacement Plan, 2000 N. Lincoln Park West, Chicago, Illinois 60614, or call 312-477-7500.

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There have been many articles and editorials published recently advocating transfusion of red cells (packed cells) rather than whole blood. The American Medical Association Committee on Transfusion and Transplantation has recently issued a formal statement on this matter<sup>1</sup> which states, "Transfusion of red blood cells (also referred to as concentrated, packed, or enriched red blood cells) rather than whole blood, is generally the best and safest method of fulfilling a patient's need for increased oxygen carrying capacity, whether that need results from chronic anemia or acute blood loss. A routine request for "blood" might well imply red blood cells rather than whole blood. The routine use of whole blood can no longer be justified."

# Red Cell

## (Packed Cell)

### Transfusions:

## An Appeal to Reason

JOHN V. PETRUCCI, MD  
Medical Director  
Baltimore Regional Red Cross Blood Program  
Associate Pathologist  
Mercy Hospital  
Baltimore



The American Association of Blood Banks is currently sponsoring workshops throughout the country on component therapy and has published a pocket-sized booklet which discusses this subject.<sup>2</sup> At least one hospital in the greater Baltimore area has sent a copy of this booklet to all its staff members. Despite all of these efforts, red cell transfusions are not given as frequently as they should be. It is stated by the American Medical Association Committee on Transfusion and Transplantation that, "It is likely that from 60% to 80% of blood transfusion needs can and should be met by use of red blood cells (rather than whole blood)."<sup>1</sup>

Two major objections to the use of red cell transfusions are usually raised.

*First objection:* The acute loss of whole blood should be replaced by whole blood since the volume of a unit of red cells is considerably less than that of whole blood.

Obviously, massive acute hypovolemia due to blood loss requires replacement by whole blood. However, in most cases involving acute blood loss, especially surgical blood loss, the loss is not massive. I would estimate that in most cases, acute blood loss at surgery is no more than 1000 ml. If this loss were to be replaced with red cells, the overall volume difference is only 400 ml. Usually the patient is also receiving a physiological solution during surgery. This can easily replace the 400 ml. In fact, the use of balanced salt solutions alone is advocated by some authors.<sup>2</sup>

The acute loss of 450 ml of blood within six to ten minutes carries an infinitesimal risk in a healthy adult. Some 6 million individuals a year experience such a blood loss, namely blood donors.

*Second objection:* The surgical patient does better with whole blood since he needs the proteins which are present in the plasma.

Actually, an average serving of meat or two eggs will supply more protein than the plasma from one transfusion.<sup>2</sup> If a patient truly requires supplemental proteins, the therapy of choice would be salt-poor albumin or purified protein derivatives. These products have the great advantage of not transmitting hepatitis.

The ability of an individual to replace his proteins is remarkable. It is perfectly safe in most instances to remove up to 1000 ml of plasma every week for many months in a healthy individual. In fact, these

are the standards set by the American Association of Blood Banks.<sup>3</sup>

The positive reasons for the use of red cells rather than whole blood are many. I will only point out the most important ones.

Most patients who have a red-cell-mass deficit do not have a significant plasma volume deficit. In fact, they usually have a plasma volume excess. In studying the blood volume reports for a one-year period at Mercy Hospital, it was found that 154 patients had red-cell-mass deficits. The recommended therapy in 152 (98.7%) of these patients was red cell transfusions. If whole blood were to be used to replace the red-cell-mass deficit, 152 of these patients would have been overloaded, some to a very significant degree.

One of the often overlooked reactions to blood transfusions is overloading. Although it is very difficult to prove, this may be the cause of a significant number of deaths. Acute pulmonary edema, as we all know, is the immediate cause of death in many hospitalized individuals.

Most blood transfusions are given to increase the patient's oxygen carrying capacity. Only the red cells in blood accomplish this purpose.

The use of red cell transfusions reduces the amount of potassium, sodium, citrate, ammonia, and acid transfused. The benefits of this are obvious. The transfusion of the waste products found in donor blood would also not appear to be beneficial.

If plasma can be salvaged as a result of red cell transfusions, it can be frozen and used therapeutically in many instances. It can also be fractionated into many useful products such as albumin, Factor VIII, gamma globulin, hyperimmune globulins, and fibrinogen. The list of therapeutic fractions is steadily increasing and many fractions are in short supply. Physicians charged with the responsibility of treating hemophiliacs are surely aware of the shortage of Factor VIII concentrate.

Lastly, since many authorities have urged the use of red cell transfusions instead of whole blood transfusions, and there are instances where whole blood transfusions may be contraindicated, it may soon become a medicolegal issue. For instance, could the use of whole blood transfusions rather than red cell transfusions be the grounds for a malpractice suit?

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# Cephalexin:

*Effective Oral Antibiotic*

*For Coccal Infections*

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Cephalexin, a semi-synthetic derivative of cephalosporin C, provides a range of antibacterial effectiveness similar to other cephalosporins and produces serum concentrations after oral administration comparable to those achieved by other cephalosporins after parenteral administration.<sup>1-3</sup> Cephalexin has demonstrated uniform efficacy in the treatment of gram-positive coccal infections and frequent efficacy in the treatment of gram-negative bacillary infections.<sup>4,5</sup> Toxic reactions have been infrequently reported.<sup>5</sup>

The study reported herein was designed to evaluate the effectiveness and toxicity of this agent at varying serum levels and at varying dosage schedules in infants and children whose illnesses were presumably due to susceptible coccal organisms.



During the period March 1, 1969 to January 1, 1970, 77 patients seen in the outpatient clinics or on the pediatric service of Mercy Hospital, Baltimore, with infectious disease presumed to be due to coccal organisms sensitive to cephalixin were entered into this study. An additional seven newborn patients were treated expectantly because of the likelihood of systemic infection. Cephalixin monohydrate was administered in two dosage schedules, 50 mg for every kilogram of body weight each day and 100 mg for every kilogram of body weight each day orally in equally divided doses at six-hour intervals. Additional therapy was provided as indicated and did not vary significantly from usual management procedures. Additional antibiotics were not used.

Thirty-eight patients were determined to have a specific bacterial infection by the isolation of a pathogenic organism from cultures of appropriate materials. Twenty-five of these were systemic infections while 13 were superficial or localized. Thirty-nine patients were determined to be diseased and an infection with a cephalixin-sensitive bacterium was presumed, but no etiologic organism was directly isolated. Cephalixin was administered until resolution of the signs and symptoms of disease was complete or for a minimum of seven days.

A complete blood count, urinalysis, serum glutamic oxalacetic transaminase (SGOT) determination, and blood urea nitrogen (BUN) determination were performed in all patients at the time of institution of therapy, at weekly or lesser intervals thereafter, and at the termination of therapy. Demonstration of the presence of infection was attempted in each patient by culture of blood, urine, stool, cerebrospinal fluid, nasopharyngeal secretion, or available exudate at the site of focal infection. Pulmonary infections were evaluated by percutaneous lung aspiration. Culture of appropriate material was repeated periodically to demonstrate eradication of infection.

Serum specimens for assay of cephalixin content were obtained from all treated patients at various times after the initiation of therapy and at various intervals after the most recent dose. All assays were performed by the cup plate method using *Sarcina lutea* as the test organism. The sensitivity of all pathogenic isolates to cephalixin was determined by the single-disc agar plate method.

### Results

Staphylococci, pneumococci, Hemophilus influenzae, and Group A beta-hemolytic streptococci were eradicated when detected in all treated patients and all such patients, including four with bacteremia, recovered promptly. All of the isolated strains of these organisms were considered to be sensitive by the single-disc agar plate method. All but two of 39 patients with infectious disease of unknown etiology recovered without incident following treatment

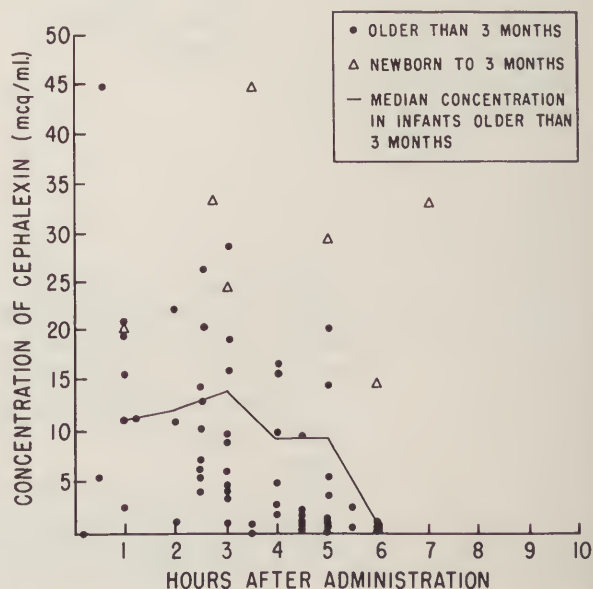
with cephalixin. Seven newborn patients were treated expectantly because of the increased likelihood of bacterial infection. Infection did not occur in any patient so managed.

No significant toxic reaction to cephalixin was detected.

INFECTION	ORGANISM	NUMBER OF PATIENTS	BACTERIOLOGIC CURE	RECOVERY	FAILURE
1. UPPER RESPIRATORY TRACT (INCLUDING MIDDLE EAR)	1. BETA HEMOLYTIC STREPTOCOCCUS GROUP A	17	17	17	
	2. UNOETERMINED	19	—	18	1
2. SKIN AND SOFT TISSUE (INCLUDING TRAUMATIC AND SURGICAL WOUNDS)	1. STAPHYLOCOCCUS	6	6	6	
	2. BETA HEMOLYTIC STREPTOCOCCUS GROUP A	7	7	7	
	3. UNOETERMINED	5	—	5	
3. BRONCHOPNEUMONIA	1. O. PNEUMONIAE	4	4	4	
	2. UNOETERMINED	15	—	14	1
4. SEPSIS	1. STAPHYLOCOCCUS AUREUS	1	1	1	
	2. H. INFLUENZAE	2	2	2	
	3. O. PNEUMONIAE	1	1	1	
5. NEWBORNS (FOLLOWING PROLONGED RUPTURE OF MATERNAL MEMBRANES)	1. UNOETERMINED	7	—	7	
TOTAL		84	38	82	2

### Clinical Response to Treatment with Cephalixin

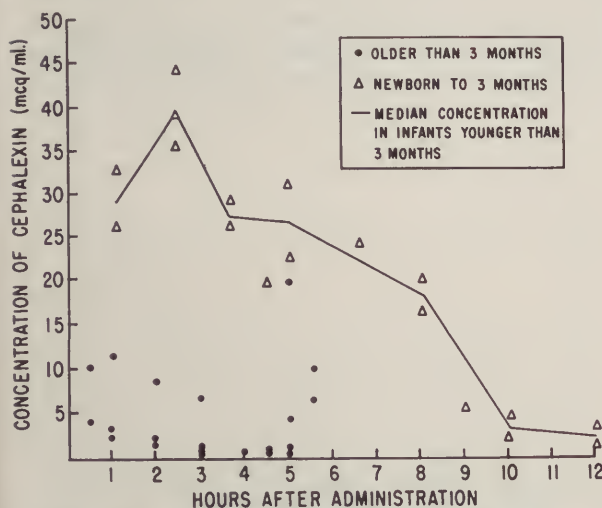
The highest serum concentrations of cephalixin in children over three months of age were detected between one and three hours after dosing. The average serum concentration during this period was 4.3 µg/ml after dosing every six hours at 50 mg/kg/day and 13.6 µg/ml after dosing every six hours at 100 mg/kg/day. Concentrations below 1 µg/ml were noted as early as two hours after dosing at 50 mg/kg/day but not until the fourth hour after dosing at 100 mg/kg/day.



Cephalixin Serum Concentration (25 mg/kg/dose) After Dosing at 100 mg/kg/24 hr



Newborns and other infants less than three months of age treated at the same dosage exhibited higher serum concentrations of the drug than did older children. Serum concentrations between 15 and 45 mg per ml were detected between one and seven hours after dosing at 100 mg/kg/day. An average serum concentration of 27  $\mu$ g/ml was achieved during the first eight hours after dosing at 50 mg/kg/day.



Cephalixin Serum Concentration (12.5 mg/kg/dose) After Dosing at 50 mg/kg/24 hr

### Comment

The in vitro antimicrobial activity of cephalixin is less than that of the other cephalosporin antibiotics,<sup>1,4</sup> but its excellent oral absorption and, consequently, higher blood levels compensate for this deficit.<sup>1</sup> Perkins, et al<sup>2</sup> noted that Group A streptococci were consistently sensitive to cephalixin in vitro. Pneumococci and penicillin-G resistant staphylococci were less sensitive but the minimum inhibitory concentrations required were regularly within the range achievable in vivo. All strains of Group A beta hemolytic streptococci and *Diplococcus pneumoniae* studied by Levison, et al<sup>5</sup> were inhibited by less than 6.3  $\mu$ g/ml and all strains of *Staphylococcus aureus* by less than 12.5  $\mu$ g/ml.<sup>6</sup>

The major advantage of cephalixin is its stability in acid media which accounts for the consistently high serum concentrations achieved after oral administration.<sup>1,7</sup> An average 80% to 93% of the oral cephalixin dose is accounted for in the urine collected in a six- to eight-hour period after administration.<sup>6,7</sup> A mean peak serum concentration of 7.7  $\mu$ g/ml after a single dose of 250 mg<sup>7</sup> and a mean peak concentration in excess of 11  $\mu$ g/ml after a single dose of 500 mg<sup>5,7</sup> were achieved in normal adult volunteers.

In studies of experimental coccal infections in mice, cephalixin was found to be more effective than

cephaloglycin, tetracycline, or chloramphenicol.<sup>1</sup> In experimental Group A streptococcal infections in monkeys, intragastric administration of cephalixin was found to be as effective as cephalothin given in equal intramuscular dosages (although less effective than cephaloridine).<sup>4</sup> Similar results were obtained in the treatment of staphylococcal infections in monkeys.<sup>3</sup> Although minimum inhibitory concentrations of cephalixin for strains of hemolytic streptococci and staphylococci were consistently higher than those of cephalothin and serum antibacterial activity levels were consistently lower, clinical results were consistently similar.<sup>3,4</sup> A recent study<sup>8</sup> indicates that cephalixin compares favorably with phenoxymethyl penicillin and ampicillin in eradicating Group A streptococci from the pharynx in man. Endocarditis due to a coagulase negative staphylococcus has been successfully treated with cephalixin.<sup>9</sup>

### Summary

The study reported herein indicates that effective serum concentrations of cephalixin may be achieved in children with a dosage of 100 mg/kg/day, and in newborns with a dosage of 50 mg/kg/day. The average serum concentrations achieved were in excess of those required for inhibition of pathogenic cocci for three or more hours after dosing. Dosing at six-hour intervals was demonstrated to be adequate for the management of the coccal infections encountered in the present study including both pneumonia and sepsis.

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Podiatry, as defined by state law, is "the diagnosis, surgical, medical, or mechanical treatment of all ailments of the human foot; with bone and joint surgery posterior to the bases of the metatarsals, the amputation of a toe or toes, and the use of an anesthetic other than local prohibited."

Although this definition was adopted in 1967, after agreement with the Medical and Chirurgical Faculty of the State of Maryland, the Board of Podiatry Examiners believes that the practice of podiatry in the State of Maryland is not well understood. Repeated inquiries have been received about the right of a podiatrist to request diagnostic procedures such as laboratory studies, X-rays, and biopsies. Inquiries concerning the right of a podiatrist to prescribe systemic medications have also been received.

# The Practice of Podiatry

## in the

# State of Maryland



The Board of Podiatry Examiners of the State of Maryland is appointed, under law, by the Board of Medical Examiners of the State of Maryland. It is comprised of four members. Three of these members are podiatrists and one is a physician. The three podiatrists are selected from a membership list prepared by the Maryland Podiatry Association, and the physician is a member of the Board of Medical Examiners.

### **Licensing Procedure**

Maryland state law requires that an applicant for a license to practice podiatry must have completed two years of pre-professional training in an approved college or university, consisting of 60 semester hours. Thirty-two hours are required subjects; 28 hours are elective subjects. An applicant must have completed four years at an accredited college of podiatry. There are five such schools in the United States.

These colleges have courses very similar to the medical college curriculum, but the emphasis is on the foot, of course. Systemic diseases and their effects on the foot are studied. Pharmacology and Therapeutics is an important subject, and while it is not as intensively taught as in a medical school, the podiatrist is required to thoroughly know those drugs that will be involved in the limited writing of prescriptions that he will use in his practice.

Upon graduation, all graduates take the examination of the National Board of Podiatry Examiners which is quite comprehensive, and includes the following:

- Part 1: Anatomy, Histology, Embryology  
Bacteriology  
Biochemistry  
Pathology  
Pharmacology and Materia Medica  
Hygiene and Public Health
- Part 2: Dermatology and Syphology  
Jurisprudence and Ethics  
Orthopedics and Foot-Gear  
Podiatric Medicine, Physical Medicine,  
Therapeutics  
Podiatry, Hospital Protocol

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**ARCHIE ROBERT COHEN, MD\***  
**President of the Board of Podiatry**  
**Member of the Board of Medical Examiners**  
**State of Maryland**

*\* Although Dr. Cohen was President of the Board of Podiatry when this article was submitted (January 1969), he is no longer associated with the Board of Medical Examiners. His term of office expired on July 1, 1969.*

### **Radiology, Foot Pathology, Diagnosis Surgery and Anesthesia**

After graduation, most applicants have taken or plan to take a one-year internship in a podiatry or general hospital.

The applicant for podiatry licensure in Maryland is given a written examination. Grades from the examination of the National Board of Podiatry Examiners (furnished by the Board after the applicant has taken the examination) are acceptable in lieu of a written examination in Maryland. The applicant is also given an oral and a clinical examination. The examination in Therapeutics and Pharmacology is given by the physician member of the Board of Podiatry.

### **Duties of the Podiatrist**

The podiatrist treating a foot problem due to diabetes is expected to be knowledgeable in the progress of diabetes as it affects the foot, and to treat the foot problem while the patient is under the care of a physician for his systemic disease.

Similarly, a podiatrist seeing a patient with a foot problem in which diabetes mellitus is suspected, is expected to order appropriate tests to confirm the diagnosis and to then refer the patient to a physician for treatment of the systemic disease. However, the podiatrist continues to treat the foot problem in consultation with the physician.

The podiatrist is permitted to prescribe systemic and local medication as would normally be expected to be effective in treating the foot condition.

The podiatrist is also permitted to use X-rays when diagnosing, examining, and treating the foot. He is expected to order biopsy examination of tissue removed at surgery, and it is quite ethical for the pathologist to perform this service, in the same manner as the pathologist would do on a physician's request.

Physicians may ethically refer patients to podiatrists, and consult with the podiatrist. Approximately 50% of the faculty of the College of Podiatry are physicians.

The Joint Commission on Accreditation of Hospitals has taken formal action regarding podiatrists on the Medical Staff of Accredited Hospitals, and has published in Bulletin 44 (April 1967) of the JCAH the following, which is a partial quotation:

"The governing body of a hospital, on recommendation of the medical staff, may grant a qualified podiatrist privileges within his area of practice. The medical staff must evaluate the qualifications of each podiatrist who applies for hospital privileges."

I trust that this article will help to clear up any possible misunderstandings regarding the role of the physician and the podiatrist, and help to point out how these two fields of medical care can assist one another.



Rupture of a ventricular papillary muscle represents a rare complication of myocardial infarction. Cederqvist and Söderström<sup>1</sup> reported five cases of papillary muscle rupture in their personal series of 4,741 autopsies for an incidence of 0.11%. Papillary muscle rupture occurred in 0.9% of the 578 acute myocardial infarctions present. They further summarized a list of published autopsy series wherein rupture of a papillary muscle secondary to myocardial infarction was noted in 24 of 56,000 autopsies, irrespective of cause of death, for an incidence of .04%. Rupture of a papillary muscle was noted to have occurred in .79% of 1,263 myocardial infarctions. Lotti, et al, found five cases of papillary muscle rupture in 3,300 autopsies (.15%).<sup>2</sup>

# A Case of Isolated Papillary Muscle Infarction with Rupture

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Maurice and Seroussi, in 1963, reviewed the world literature and listed 84 cases of spontaneous rupture of papillary muscle from all causes, 60 of which were due to myocardial infarction.<sup>3</sup> Other etiologic factors have been trauma,<sup>4-7</sup> syphilis,<sup>8</sup> endocarditis,<sup>7,9-10</sup>

periarteritis nodosa,<sup>11</sup> disseminated lupus erythematosus,<sup>12</sup> and myocardial abscess.<sup>13</sup> In 1966, Gomez and Jackson reported a total of 115 cases of ruptured papillary muscle from all causes in the literature.<sup>14</sup> Since their tabulation, several other cases



have appeared, bringing the current total to about 125 including the following case report.<sup>2,15-18</sup> This interesting case represents a focal infarction of the left ventricular posterior papillary muscle only, without ventricular wall infarction, and was associated with a thrill on examination. The finding of isolated papillary muscle infarction and the presence of a thrill in association with a ruptured papillary muscle represent rare aspects of this entity.

### Case Report

A 51-year-old woman had been a diabetic for at least five years. She was maintained on 15 units of NPH insulin daily. Ten days prior to death, the patient went out of town and failed to take her medication with her. When she returned to Baltimore, eight days prior to death, she complained of "cramps in her stomach" which persisted as diffuse abdominal pain with vomiting on two occasions. There was no history of chest pain, diaphoresis, or shortness of breath. The patient failed to take insulin on her return, and lethargy developed. Six days prior to death, she came to the emergency room because of increasing lethargy and generalized abdominal discomfort, the latter without diarrhea, hematemesis, chills, or fever. She was subsequently admitted for evaluation.

The patient had no known history of hypertension, cardiac disease, chest pain, or symptoms of congestive heart failure. She did admit to constant swelling of the legs dating six months prior to death. The respiratory, gastrointestinal, and genitourinary systems were negative in the systems review. The family history and past history were non-contributory.

On physical examination, the patient presented as an obese woman in mild distress due to abdominal discomfort. The blood pressure was 150/80, with a pulse of 90 and regular, respirations were 27, and the patient was afebrile. Funduscopic examination revealed bilateral capillary aneurysms, with grade III K-W eyegrounds. The lungs were clear to auscultation and percussion. The heart revealed a PMI 1 cm to the left of the midclavicular line in the fifth intercostal space with the left border of cardiac dullness in the same location. A systolic thrill was present at the apex. Heart sounds were of good quality with S-2 physiologically split and with A-2 greater than P-2. A grade III/VI systolic, blowing, ejection-type murmur was heard at the apex and along the left sternal border. No diastolic murmur was present and no rub or gallop was heard. The radial, femoral, posterior tibial, and dorsalis pedis pulses were equal and adequate. One-plus sacral and 3+ bilateral ankle and pretibial edema were present. The abdomen was soft with voluntary guarding and generalized tenderness without organomegaly or masses. The patient noted her discomfort to be mid-

line extending from the xyphoid to the umbilicus. There was no evidence of conjunctival, oral mucosal, cutaneous, or nailbed petechiae. The admission hemogram was unremarkable. The fasting blood sugar was 612 mg/100 cc with "light" serum acetone. Urinalysis revealed a specific gravity of 1.028 with "light" glycosuria and 3+ albuminuria. The BUN was 39 mg/100 cc, serum creatinine 2.2 mg/100 cc, and CO<sub>2</sub> 20 mEq/L. The serum albumin was 1.3 gm, globulin 4.1 gm, serum cholesterol greater than 500 mg/100 cc with a 24 hour urinary protein of 2.99 gm. The SGOT and SLDH were within normal limits and an EKG revealed widespread ST-T changes without evidence of infarction. The VDRL and RPR were nonreactive.

The patient was placed on a sliding scale insulin regimen, subsequent to which her diabetic status failed to present a serious problem. On the second hospital day, four days prior to death, the patient's abdominal symptoms subsided, but her rectal temperature had risen gradually to 101.6 F. There were negative respiratory signs and symptoms; however, a sputum smear revealed gram positive diplococci, and cultures subsequently revealed heavy growth of *Diplococcus pneumoniae*. Three blood cultures were positive for 27 to 30 colonies of *Diplococcus pneumoniae*. A lumbar puncture was unremarkable. The patient was placed on 20 million units of aqueous penicillin IV daily. Her admission murmur did not reveal any change. Two days prior to death, the patient's rectal temperature was in the 98 F to 99 F range but increasing tachypnea associated with bilateral basilar rales and expiratory wheezes was noted. There was an absence of chest pain and P-2 was not accentuated. The patient, felt to be in incipient pulmonary edema, was begun on digitalis and treated with sodium mercaptomerin (*Thiomerin*), aminophyllin, morphine, and nasal oxygen. One day prior to death, rotating tourniquets and ethacrynic acid were added to her regimen. Orthopnea developed and her tachypnea increased. The systolic murmur and thrill were unchanged since admission with absence of rub, gallop, venous distension, or hepato-jugular reflex. The patient subsequently experienced a cardiac arrest from which she was resuscitated; however, vasopressors and isoproterenol hydrochloride, USP (*Isuprel*) failed to maintain her blood pressure and she died eight hours following arrest.

The clinical impression was one of diabetes mellitus with nephrotic syndrome secondary to Kimmelstiel-Wilson Disease with bacterial endocarditis and congestive heart failure.

### Anatomic Findings

The lungs, which weighed 1,430 gm, were edematous and acutely congested. There was 150 cc of cloudy yellow pleural fluid on the left which upon



culture yielded light growth of coagulase negative *Staphylococcus aureus*, felt to be a contaminant. Blood culture was negative. The pericardial lining was unremarkable and the sac contained 75 cc of tea-colored clear fluid. The heart revealed a smooth, glistening epicardial surface. The coronary arteries were of normal size with diffuse, mild plaque formation of the proximal portions of both coronary arteries with a focal area of marked plaque formation of the terminal portion of the posterior descending branch of the right coronary artery. An occlusive thrombus was not present. Upon entering the left atrial chamber, an avulsed papillary muscle tip with its attached tendinae was noted to be lying on the atrial side of the mitral valve. The chordae were not entwined or twisted. There was no evidence of bacterial vegetation. Cut section of the heart failed to reveal any evidence of ventricular wall infarct or fibrosis; however, a fused left ventricular posterior papillary muscle was noted to be ruptured with the body of the muscle revealing a grayish-yellow necrotic, soft, inverted conical-shaped 1.2 cm infarct with a mildly hemorrhagic border (see Figure 1). The proximal base of the papillary muscle was normal in appearance without fibrosis. The avulsed tip was grayish-brown in color and 0.5 cm in length. All cardiac valves were unremarkable. The left ventricle was 14 mm in thickness and the heart weighed 320 gm. The aortic arch revealed an atheromatous spur causing moderate obstruction of the right coronary ostium. The liver, which weighed 2,150 gm, was pale and bloodless. The kidneys were grayish-yellow in appearance, weighed 220 and 250 gm, and had a finely granular surface. Other organs disclosed no pertinent findings.

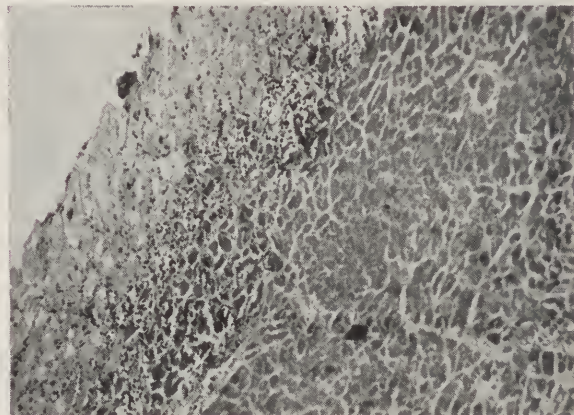


**Figure 1:** The opened left ventricle discloses the infarcted posterolateral papillary muscle with ruptured apex lying within the left atrium

#### Microscopic Findings

The lungs revealed early focal bronchopneumonia of all lobes with marked edema and intra-alveolar

hemorrhage. The left ventricular myocardium was unremarkable. A section of the posterior papillary muscle revealed a recent infarct of approximately seven days duration characterized by necrosis of muscle fibers and a peripheral polymorphonuclear response (see Figure 2). The proximal portion of the papillary muscle was unremarkable. A small artery coursing through the papillary muscle was noted to have moderate intimal thickening. There were no vegetations of the papillary muscle and bacterial stains of this muscle were negative. A section of the terminal posterior descending coronary artery revealed marked intimal proliferation and lipid deposition. The liver showed mild fatty metamorphosis. The pancreas was noted to have diffuse subtotal hyalinization of the islets. The kidneys revealed rather marked intercapillary glomerulosclerosis, of both diffuse and nodular variety, with moderate arterial and arteriolar nephrosclerosis and mild chronic pyelonephritis.



**Figure 2:** Microscopic section of the infarcted papillary muscle with necrotic myocardium (on the right) and surrounding polymorphonuclear reaction (140 X)

#### Discussion

Historically, Merat, in 1803, described the first case of ruptured papillary muscle, possibly of syphilitic origin.<sup>10,19</sup> In 1824, Bertin is cited as reporting a case of right ventricular papillary muscle rupture secondary to tuberculous vegetation while Spanton, in 1865, reported right ventricular papillary muscle rupture due to bacterial endocarditis. Davison is credited with having made the first clinical ante-mortem diagnosis of papillary muscle rupture.<sup>10</sup> Eisenberg and Suyemoto reported the first case in the English literature of infarction-induced rupture of a right ventricular papillary muscle, the previous four cases being secondary to endocarditis and trauma.<sup>20</sup>

Papillary muscle rupture as a sequella of myocardial infarction is the result, in almost all instances, of simultaneous involvement or extension from the adjacent myocardial wall. This case and



one of the five reported by Lotti, et al,<sup>2</sup> appear to be the only cases where involvement limited to the papillary muscle was noted. Thrombosis was not demonstrated in our case. However, there was marked atherosclerosis of a terminal branch of the posterior descending right coronary artery at a point approximately 2 cm from the base of the involved papillary muscle.

In addition, microscopic section of the papillary muscle revealed moderate to marked intimal narrowing of the central artery of this structure. One must also consider the narrowing of the right coronary ostium as further compromising blood flow to this vessel. Morphologically, there was no evidence of luetic aortitis; furthermore, the clinical VDRL and RPR tests were negative. The posterior papillary muscle usually has a dual blood supply from branches of both the right and left coronary arteries. However, in cases of right coronary predominance, this vessel constitutes its major source of nutrition. In such cases, the terminal branch of the posterior descending artery, the involved vessel in this case, ends directly over the posterior papillary muscle.<sup>21</sup>

Sanders, et al, and Davison both cite the meager collateral supply of this muscle as compared to its anterior fellow in explaining the six to twelve times as frequent incidence of posterior papillary rupture in comparison to the anterior muscle. The vessels feeding the former are smaller and more remote from their main source. The supply of the anterior papillary muscle arises from the left anterior descending and circumflex branches.<sup>10,22</sup> However, because papillary muscle infarction is almost always secondary to ventricular wall infarction, and due to the fact that most myocardial infarcts are of the posterior variety, the posterior papillary muscle on this basis alone could be expected to reveal an increased incidence of infarction and rupture.

To be sure, Oeser is quoted as having shown posterior papillary muscle necrosis in 20% of all posterior infarcts.<sup>23</sup> In our case, one might speculate that the localized infarct was secondary to diabetic small artery disease within the papillary muscle itself, similar to the ischemic peripheral vascular disease seen in diabetic patients who have adequate dorsalis pedis and posterior tibial pulsations. Certainly, the fundoscopic and renal vascular changes in this patient attest to small vessel disease. The precarious vascular perch of the posterior papillary muscle is further alluded to by Sanders, et al, who cite cases of necrosis and fibrous changes of the papillary muscles of young epileptics and patients dying of carbon monoxide poisoning.<sup>22</sup>

Clinically, the presence of a systolic murmur or a change in intensity of a preexisting murmur in association with myocardial infarction should suggest a differential diagnosis of ruptured papillary muscle,

papillary muscle dysfunction, rupture of the interventricular septum, or mere dilatation of the left ventricle. Obviously, the physical findings, EKG data, and clinical course must be considered together in assessing the pathological status. Both papillary muscle rupture and septal perforation can give rise to loud systolic murmurs; however, the frequency, character, and location of the murmur differ with these complications. Sanders, et al, noted the presence of a systolic murmur in 62% of his 61 summarized cases of papillary muscle rupture,<sup>22</sup> while Fowler and Failey recorded a 96% incidence of systolic murmurs in 47 cases of septal perforation.<sup>24</sup>

The true incidence of murmur associated with papillary muscle rupture is probably higher than the figure mentioned by Sanders. Many patients die without examination, and further, often a murmur may be obscured by extraneous lung sounds. The septal perforation murmur tends to almost always be systolic in timing, is located along the left sternal border in the fourth to fifth interspace, and is similar to the murmur of the congenital septal defect. In contrast, the murmur of papillary rupture is usually systolic, although in a few instances a diastolic component may be present as well. Rarely, only a diastolic murmur has been noted. The systolic murmur is heard best at the apex, is a harsh blowing type of murmur as heard in mitral insufficiency, and is frequently transmitted to the axilla. Of vital diagnostic significance is the presence of a thrill, for this finding was noted in 47% of the above mentioned series of septal perforation whereas it is exceptionally rare in papillary muscle rupture. A thrill in association with papillary rupture has been noted in our case and those of Hope and Askey,<sup>25</sup> Adicoff, et al,<sup>26</sup> and Hackel and Kaufman.<sup>13</sup> Further differential points are: (1) anterior infarction is seen in 75% of cases of perforated septum; and (2) conduction defects, particularly right bundle branch blocks, are seen in over one third of septal perforations. Papillary rupture is usually related to a posterior infarct, as noted above, and rarely reveals conduction defects.

Clinically, the course following papillary muscle rupture is classically one of severe left ventricular failure with rapid intractable pulmonary edema. Deterioration in septal perforation is more gradual and tends to manifest as venous and hepatic congestion rather than pulmonary. As for papillary muscle dysfunction and left ventricular dilatation, the associated murmurs are an apical "ejection" type or soft pansystolic murmur, respectively. Their courses, generally benign, are not associated with the abrupt circulatory changes as seen in papillary muscle rupture. Cardiac dilatation leads to gradual increase in heart size with increasing intensity of the murmur over a period of a few days.<sup>10-11,15,22,27-28</sup> It should



be said that chordae tendinae rupture may simulate the findings seen in papillary muscle rupture; however, the former condition is almost always secondary to endocarditis and tends to manifest slow deterioration with prolonged survival.<sup>10</sup> Of interest, however, are four cases of ruptured chordae believed secondary to coronary artery disease.<sup>16</sup>

Askey<sup>11</sup> noted several cases of papillary rupture accompanied by a friction rub with negative evidence of pericarditis at autopsy. He felt this represented intracardiac mimicry of the pericardial friction rub, possibly related to the motion of twisted chordae tendinae as proposed by Lowry and Burn.<sup>29</sup> Harder and Brown discussed in detail the torsion patterns and spiral twisting of the avulsed papillary tip and recorded that such twisting occurred in 32% of the 57 reported cases at that time and that this event tended to aggravate mitral deformity and dysfunction.<sup>30</sup>

As already indicated, papillary muscle rupture leads to severe cardiac failure. Sanders, et al, based on 56 cases, reported a 20% mortality within one hour, a total mortality of 60% within 24 hours, and an 80% mortality through the second week.<sup>22</sup>

There are several reported cases of survivals of from 6 to 14 months, while Merat's original patient lived 20 months.<sup>11,19</sup> Adicoff, et al, reported two cases surgically treated by mitral plication with death of both occurring in the immediate postoperative period.<sup>26</sup> Horlick, et al, effected surgical repair by suturing the free end of the ruptured posterior papillary muscle to the septum and the patient was alive and improved 18 months later.<sup>16</sup> Cooley and associates reported a successful reinsertion of a ruptured right ventricular papillary muscle due to endocarditis with the patient alive and well five years later.<sup>7</sup>

## Summary

A case of left ventricular posterior papillary muscle rupture secondary to focal infarction is reported. The focal quality of the infarct, limited to the papillary muscle itself, and the clinical presence of a thrill are rare findings in association with this unusual complication of myocardial infarction. Historical aspects, incidence, clinical presentation, pathogenesis, course, and the pertinent literature are reviewed.

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**Overview**

**of**

**Fluoridation**

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This article was written primarily for the medical practitioners of Baltimore County. However, I know that many of the counties throughout the state of Maryland and throughout the country are having the same problem.

In Baltimore County, there are approximately 101,000 people who are not receiving the advantages of fluoridated water. Therefore, our clinic and private physicians are very concerned over the dispensing of a supplemental fluoride. I felt that an explanation of supplemental fluorides and the method of its dispensing would greatly help these physicians.

It has become an established dental principle that fluoride compounds are very effective in reducing the incidence of dental decay. Extensive research and experimentation have helped establish two methods of administering fluoride: systemic and topical.

Systemic fluoridation is the imparting of fluoride to the developing enamel through the blood supply. This can be accomplished by the addition of fluoride to the water supply or by the ingestion of fluoride tablets or fluoride-supplemented vitamins. (There are only trace elements of fluoride in the normal daily diet.)

Topical fluoridation may be defined as the application of a fluoride compound directly to the enamel of the erupted or erupting dentition. The fluoride may be applied:

1. By the dentist or dental hygienist;
2. By having fluoride incorporated into tooth-pastes or tooth powders;
3. By the patient after careful instruction by the dentist.

This third method is now in the experimental stage. Dr. Joseph C. Muhler and his associates have been researching the once-a-year topical application (by the patient) of a stannous fluoride zirconium silicate prophylactic paste. This method is showing some promise and may open new pathways in the preventive dentistry field.

### Most Effective Method

Topical fluoride has certain advantages over systemic fluoride. However, the most effective method of reducing decay is a combination of both methods. The outstanding advantage of the topical application is that it is beneficial no matter what age the patient may be. On the other hand, systemic fluoride, as previously stated, is only effective on the developing enamel.

Even though reducing the incidence of new caries is obtained by the direct application of fluoride solution to the surfaces of the teeth, the most important method for providing extensive protection against decay is through the drinking water. The effectiveness of fluoride ingestion at the optimal concentration of approximately one part for every million parts in the community water supply is well documented. It has proven partially effective in reducing

dental caries in children when ingested from birth to the end of the calcification stage of the dentition.

However, a significant portion of the population is not receiving the benefit of community fluoridation. They are not served by city water, or the children were beyond the age where fluoridated water is effective when fluoridation became accessible. In Baltimore County, approximately 101,000 people are not receiving the advantages of community fluoridation.

However, individual fluoridating units are available for home use. These units are connected to the water supply at the intake source (a pump in most cases). As the water flows through the unit, optimal amounts of fluoride are added to the water. The initial cost of this unit varies from approximately \$50 to \$90. The cost of the fluoride is minimal. In some cases this unit is the answer to the lack of fluoridated water. However, most people could not afford this additional expense or would not want to bother with it.

When speaking of supplemental fluoride, I refer to the administration of tablets or drops in the form of fluoride alone or fluoride in conjunction with vitamins. It should be made clear that the American Dental Association frowns upon the indiscriminate use of fluoride-backed vitamins, using the vitamin as a convenient method of administration. If the child needs a fluoride supplement, the physician or dentist should prescribe the necessary supplement. However, fluoride vitamin combinations should not be given unless there is a definite need for both substances.

### Dietary Fluorides

Dietary fluorides should be prescribed on an individual basis, since many water supplies contain natural fluoride in various concentrations. The daily ingestion of a sodium fluoride supplement by children from birth to age ten has been recommended where the water supply contains less than 0.7 parts for every million parts of fluoride.

This brings about the first major point concerning supplemental fluoride. Before prescribing a supplemental fluoride, the physician or dentist must know the natural fluoride concentration of the patient's drinking water. In northern Baltimore County, there is an almost complete lack of fluoride



in the water, as is true in numerous rural areas throughout the country. Many of these areas have tried free distribution of fluoride tablets to compensate for the lack of fluoridated water. This method of administration is greatly limited in its effectiveness. The overwhelming shortcomings in distributing fluoride tablets to such a large population tend to make this program unsuitable as a public health measure. There is difficulty in getting the tablets to all children of appropriate age, and it is most improbable that the parents will consistently give their children tablets daily for the duration of the teeth-developing years.

The above statement brings forth one of the most outstanding problems in the administration of supplemental fluorides. Such administration must be consistent and continuous over long periods of time if it is to substantially benefit a patient. Strong motivation and a clear realization of need for careful regulation of dietary intake is required on the part of the patient and the parent.

The usefulness of prescribing fluorides to expectant mothers has not been clearly demonstrated at this time. There is evidence substantiating the fact that the amount of systemic fluoride passing across the placental barrier is so minute that it has no advantageous effect to the developing child.

Because of the possible misuse and probable ineffective use of dietary fluoride, except under the most careful supervision, it is strongly advised that the indiscriminate distribution or casual prescription of supplements of dietary fluoride should not be used. Again it must be stressed that the level of fluoride in the drinking water must be established even if the supplement is only to be given to a single person in the home.

Every precaution against storing large quantities of sodium fluoride in the home should be taken. Therefore, it is recommended that no more than 264 mg of sodium fluoride be dispensed at any one time. This quantity will provide at least a four-month allowance for one child. Each package dispensed should also bear a statement in capital letters: CAUTION! STORE OUT OF REACH OF CHILDREN.

Although the optimum level of fluoride in drinking water has been established, there is no firmly established allowance of fluoride to be administered on a once-a-day basis. The tentative schedule of 1 mg a day for a child over three years of age, and half of this dosage for children between two and three years can be followed. This formula is based on extensive observation of the use of fluoride tablets where the drinking water is free of any fluoride. In order to avoid the possibility of unesthetic dental fluorosis, the prescribed dietary allowance should therefore be adjusted downward in proportion to the amount of fluoride provided in the drinking water.

The following is a table established by the Council on Dental Therapeutics of The American Dental Association for the adjustment of fluoride dependent upon the natural fluoride concentration:

Water Fluoride		Adjusted Allowance	
Parts	a million	Sodium Fluoride	Provides fluoride ion
		mg a day	mg a day
	0.0	2.2	1.0
	0.2	1.8	0.8
	0.4	1.3	0.6
	0.6	0.9	0.4

No specific daily allowance has been suggested for infants and children up to two years of age. The use of commercially bottled water containing one part for every million parts of fluoride can be used for the child's drinking purposes and mixed with formulas when it calls for water.

The following is a sample prescription that could be used for sodium fluoride where the water is lacking a fluoride ion:

Rx

Sodium fluoride tablets 2.2 mg

Dispense 100 tablets

Sig: 1 tablet each day in one-half glass of water or fruit juice

CAUTION: STORE OUT OF REACH OF CHILDREN

One 2.2 mg tablet of sodium fluoride dissolved in a quart of drinking water will provide fluoridated water that may be used for infants.

If you are working with the adjustment table set by the Council on Dental Therapeutics, the following prescription can be used:

Rx

Sodium fluoride 0.6 gm

Distilled water to make 60 ml

Dispense in plastic dropper bottle that delivers 20 drops for each millileter

Sig: Use ( ) drops each day in half glass of water or fruit juice

CAUTION: STORE OUT OF REACH OF CHILDREN

Each drop of this preparation will provide 0.1 ml of fluoride ion and the appropriate number of drops (eight, six, or four) is specified on labeled directions according to the table of adjustment allowances.

Proprietary sodium fluoride preparations are now available in both tablet and solution form, and have received a group B classification by the Council on Dental Therapeutics of the American Dental Association.



ciation. Group B classification includes these preparations which lack significant evidence to justify present acceptance but for which there is reasonable evidence of usefulness and safety.

There has been a recent trend to combine vitamins and sodium fluoride in fixed combinations for infants and very young children. These combinations are not regarded as rational by the council because of the difficulties involved in adjusting the fluoride allowance to the varying levels of water fluoride in many communities.

### **Over-Fluoridation**

The result of over-fluoridation can be quite disturbing to the appearance of an individual. It can also cause a possible severe health hazard. Mottled enamel or dental fluorosis are the dental results of over-fluoridation and can easily occur through the ingestion of excessive amounts of fluoride over an extended period of time. The mottled enamel leaves the dentition permanently stained and, in many cases, permanently malformed. These conditions do not appear until the eruption of the secondary dentition. Therefore, it is quite conceivable that unless the dose is regulated properly, a child could be placed on an overdose of fluoride supplement and never know it until four to six years after the damage has been done.

The above should concern all individuals interested in supplemental fluoride. Mottled enamel or dental fluorosis is irreparable without great difficulty, much discomfort, or extreme cost. However, in most cases, a decayed tooth is restorable with ease and at no great expense.

The following is an informal suggestion prescribing fluoride supplements.

### **Procedures For Dentists**

1. Prescribe preparations which contain only fluoride as a supplementing agent. There is no evidence that vitamins including fluoride have any greater dental effect than fluoride alone. Therefore, the determination of vitamin supplement is still the job of the physician.

2. Always determine first the fluoride level in the child's drinking water. If the child lives in a rural area and is on well water, an analysis of this water is necessary for complete safety. Also, make sure the child is not already receiving other supplements of prescribed fluoride.

3. Make an estimate of the amount of cooperation that can be expected from the responsible adult, usually the child's mother.

4. Prescribe according to the principles which are outlined by the Council on Dental Therapeutics.

The two prescriptions provided in the text of this report are taken from the Council on Dental Therapeutics and can be used as examples for the actual prescriptions.

### **Procedures For Pediatricians and Other Physicians**

1. The dental profession welcomes the cooperation of the physician in insuring availability of proper dietary fluoride to all children. This is best achieved through a fluoridated water supply. However, supplemental dietary fluoride must be considered in some cases and only as a stop-gap procedure.

2. For infants and children up to two years of age, avoid the use of fluoride-vitamin mixtures. Pediatric studies reveal the daily allowance for infants now obtainable may lead to objectionable fluorosis of the anterior dentition. When indicated, fluoride should be prescribed separately. The prescription included in this report can be used as an example.

3. For children three years old and older, fluoride may be prescribed separately. Do not use vitamin-fluoride mixtures unless the child's drinking water is substantially free of fluoride and the child also needs vitamins. The vitamins should not be used as a vehicle for the fluoride. There is presently no uniformity in the labeling directions for administering commercial fluoride-vitamin preparations.

4. Contrary to some promotional claims, there is no clear indication that supplements of dietary fluoride administered to expectant mothers will provide substantial protection to the deciduous teeth of the offspring. However, there is no hazard anticipated to either the mother or the child from the supplements usually suggested in the labeling of commercial products.

5. Thoroughly evaluate the proposed cooperation by the adult member of the family, usually the mother, who would administer the fluoride supplement.

6. Make sure the child is not already receiving a supplement of fluoride prescribed by either another physician or dentist.

### **Overview**

In conclusion, the intrinsic value of fluoridation, whether systemic, topical, or a combination or both, has been proven for years. What is now the focus of our attention is the value of supplemental fluorides. However, I feel that it has been ascertained that when they are distributed properly, under careful supervision, they are definitely beneficial.

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*Bibliography supplied upon request*



# **your medical faculty at work**

by John Sargeant  
Executive Director

**The Council met on November 19, 1970, and took the following actions:**

1. Instructed the Faculty's Delegates to the American Medical Association to introduce a resolution into the AMA House to compile economic data on the cost of operating a physician's office practice;
2. Approved the Dedicated Fund Statement and Financial Operating Statement through September 30, 1970;
3. Approved the meeting date for the 1971 Semiannual Business Session of the House of Delegates as Saturday, September 11, 1971, at 2 PM in the Faculty building;
4. Approved Executive Committee and Council meeting dates for 1971;
5. Authorized appointment of legal counsel for 1971 on the same terms and conditions as for 1970. (Anderson, Coe and King are legal counsel for the Faculty);
6. Referred material received about the 1971 White House Conference on Aging to Emerson C. Walden, MD, Faculty representative on the Governor's Commission on Aging;
7. Commended the Federal Aviation Agency for adopting a policy prohibiting crew members of private planes from consuming alcoholic beverages within eight hours before flying private planes;
8. Designated the Executive Director as legislative representative for the 1971 General Assembly in Annapolis;
9. Authorized a dinner meeting with Maryland's Congressional Delegation to be scheduled early in 1971;
10. Adopted the following motion concerning the delivery of medical care:  
The Faculty supports the concept that medical care can be delivered through various mechanisms, including closed panel programs; provided individual physicians render such health care on an equitable basis and further provided that the patient has the right to choose the mechanism through which he will receive such health care.
11. Approved cooperating in a preceptorship program operated by the Student American Medical Association and appointed William L. Stewart, MD, as Faculty representative on a joint committee to develop such a program;
12. Approved the principle that medical school enrollment should be increased and additional medical schools be established, and authorized the Public Relations Chairman to amend the motion presented by the Public Relations Committee, in cooperation with two members of the Council;
13. Accepted a report from the Public Relations Committee that the Faculty should not develop material dealing with items that are not covered under Medicare and approved further study to determine whether a pamphlet should be published with other health-care providers to explain the health-care dollar and its components;
14. Authorized loaning 10 to 15 significant items from the Faculty's historical collection to the Smithsonian Institute. These items date back to the earliest period of the Faculty's existence;
15. Authorized the Executive Director to further pursue the question of storing other items at the Smithsonian and report back to the Executive Committee;
16. Adopted proposed Peer Review Guidelines and urged that Councilors take them back to components in their districts and urge formation of similar committees on a local level.

*(Continued next page)*



**The Executive Committee met on Thursday, December 10, 1970, and took the following actions:**

1. Decided to further pursue a question raised by law enforcement officials in Kent County concerning examinations by physicians in possible criminal cases;
2. Directed the Faculty office to prepare a list of ENT specialists who perform audiometric testing; such a list is to be used in answering inquiries concerning referrals as to who performs such tests;
3. Authorized dissemination to the news media of the following advisory message regarding air pollution:

### **AIR POLLUTION CRISES**

#### **Warning—Stay Indoors**

If you are a victim of chronic bronchitis, asthma, pulmonary asthma, pulmonary emphysema, or other chronic heart and lung conditions, your best means of protection during an air pollution crisis is to remain indoors.

The Medical and Chirurgical Faculty of the State of Maryland advises persons suffering from any form of chronic lung disease or whose lung disease has heart complications, to remain indoors with windows closed, preferably in an air conditioned room or in a room with a circulatory fan.

Such persons are also advised to stop smoking, to stay away from places where others are smoking, and to omit activities which raise dust, such as vacuuming or dusting. During the heating season avoid starting fires in fireplaces and use extreme care in starting hot-air furnaces.

Avoid undue exertion and exposure to cold. The Medical and Chirurgical Faculty recommends that those individuals with severe lung or heart ailments should go to bed to relieve strain and improve their breathing capacity during an air pollution crisis.

If lung or heart symptoms increase, the individual should contact his physician at once.

4. Authorized dissemination to physicians of the following advisory message regarding air pollution:  
In the course of treatment of common respiratory conditions during periods of air pollution crises, there should be increased use of moist inhalations, bronchodilators, and broad spectrum antibiotics during and for several days after air pollution episodes have abated. Cough suppressants, antihistamines, and sedatives in general contribute to allowing secretions to build up and precipitate acute respiratory failure by suppressing ventilatory drive, and should be judiciously avoided during this period. The use of corticosteroids may be helpful for a short period. Hospitalization is necessary for an intense pulmonary regimen, particularly for severe hypoxia and hypercapnia. The latter may be better identified by arterial blood gases.
5. Directed that a message regarding "legal abandonment" be carried in the Executive Director's Newsletter;
6. Officially adopted a recommendation that physicians perform routine prenatal STS and rubella HIA tests;
7. Approved recommending to the Motor Vehicle Commissioner that all individuals over age 65 be reevaluated for vision and driving ability when applying for license renewal;
8. Approved sending to the news media a copy of an editorial appearing in *JAMA*, June 8, 1970, on automobile fatalities and accidents;
9. Authorized advancing funds to the Woman's Auxiliary, to be refunded from proceeds of its Project HOPE, to implement a benefit dinner for this public service project;
10. Authorized the filing of injunctive proceedings in connection with the use of the term "Chiropractic Physician" and the preparation of a press release in this connection at the same time that the suit is filed;
11. Directed that Monday, December 28, 1970 be observed as a Faculty holiday;
12. Approved filing a protest with the Secretary of Health and Mental Hygiene in regard to action establishing a fee schedule for clinical laboratory services for medicaid patients; and the payment of such services on the basis of 60% of such a schedule;
13. Selected William Carl Ebeling, MD, of Baltimore, to serve as an interim AMA delegate to replace Charles F. O'Donnell, MD, of Towson, who has become a full delegate to the AMA.





NEIL SOLOMON, MD, PhD, SECRETARY

## Maryland State department of health and mental hygiene

### Home Health Services in the Care of the Chronically Ill

The concept of the care of the chronically ill home-bound patient in his home surroundings is certainly nothing new.

In the past, physicians cared for many of their patients at home. This is essentially a bygone era. Physicians, with few exceptions, can no longer justify the time-consuming home visit with the attendant inadequacies for diagnosis and treatment. If such home-bound patients are to receive total supervision from their physician, they must find their way to the physician either in his office or in an institution.

Departments of health have rendered home-care services to the chronically ill for years. However, the level of care has varied tremendously and in general, because of staffing patterns, has been minimal. The service has been largely of an educational type—interpreting the disease processes and instructing the patient and his family in care techniques recommended by the patient's physician.

The visiting nurse associations, limited mainly to larger metropolitan areas, have offered bedside nursing services to individual patients with less emphasis on total health supervision.

With the advent of Medicare, the phrase home health services was coined (and the definition is quite simple—the phrase meaning, “the deliverance of health services to a patient in his home”). These services may include skilled nursing, physical therapy, speech, occupational therapy, medical social services, and others.

A good home-health service program for all chronically ill patients combines the best of the old health department and visiting nursing association concepts and adds a different dimension. While the health department's emphasis was on health education, and the visiting nurse association's emphasis was on patient care, the home health service program emphasizes total patient (and family) super-

vision under the direction of the patient's physician.

To minimize patient discomfort and disability, to prevent repeated hospitalizations or institutionalization, to prevent family disruption, and to prevent the premature death of the chronically ill home-bound patient, a high degree of medical supervision and ancillary services are required. With the increasing number of chronically ill patients in any community and the decreasing number of physicians, physicians alone cannot be expected to be able to offer or completely arrange the variety of services required.

A well-organized home-health service program offering nursing, physical therapy, home-health aide and other services; a knowledge of the many patient resources in the community; and a rapport with the providers of service can aid the physician in delivering the services his patient needs and he desires.

Through the home-health agency, the physician has at his beck and call a tremendous medical and social team that few, if any practitioners could otherwise hope to muster. It is without logic for physicians to devote their time and skill to try to completely supervise the health care and needs of the chronically ill when it can be delegated to other professionals under their direction. It is equally without logic for such supervision to be neglected with injury to the patient and repeated and unnecessary hospitalizations or other institutional care.

Once a physician experiences working with a home-health service program as the leader of a team dedicated to the provision of total care for the chronically ill patient, the advantages to him as a physician and the advantages to his patient and his patient's family and the community become self evident.

The physician has not relinquished his role as the patient's family physician, but has enhanced it by the quality of care he can offer in this manner.



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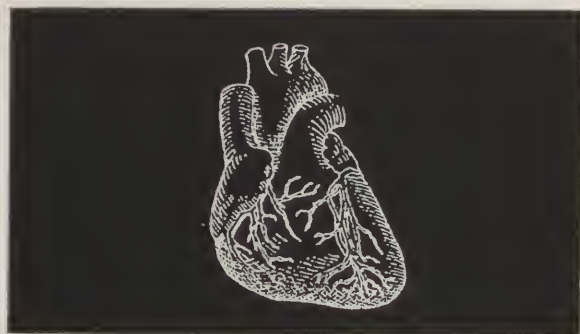
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## the heart page

# Systolic Intervals for Evaluation of Left Ventricular Function

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Noninvasive methods for evaluating cardiac function have come into increasing use over the past decade. Of these bedside techniques, systolic time intervals are enjoying current widespread attention. Systolic time intervals are obtained from simultaneous recordings of the phonocardiogram, electrocardiogram, and indirect carotid pulse (Figure 1). This technique is sensitive to hemodynamic changes and allows rapid, precise, and objective determination of left ventricular function.<sup>1-4</sup>

The systolic intervals derived are: (1) The **Q-S2 interval** (Q-2) represents the total duration of electromechanical systole. It is measured from the onset of the QRS complex in the EKG to the first high frequency (aortic) component of the second heart sound.\* (2) **Left ventricular ejection time** (LVET) is the total time of forward blood flow through the aortic valve in a given cardiac cycle. It is measured from initial rapid upstroke of the indirect carotid pulse tracing to the trough of its dicrotic

notch. (3) The **pre-ejection period** (PEP) is the time from initial electrical ventricular activation to aortic valve opening. It is derived by subtracting LVET from Q-2, both of which have been measured in the same cardiac cycle.

A fourth parameter is the isovolumetric contraction time (ICT). This is the difference between the S1-S2 interval and LVET. It is less reliable than other parameters because the mitral component of S1 is not always clearly definable.<sup>5</sup>

Q-2, LVET, and PEP are inversely related to heart rate. From normal populations, Weissler, et al,<sup>1-4</sup> have derived linear regression equations relating heart rate to systolic time intervals. These equations and their standard deviations (in milliseconds) are listed on the following page<sup>3</sup>:

\* Unless the second heart sound is paradoxically split, the first high frequency component recorded is produced by aortic closure. When S2 is paradoxically split, its first vibrations are from pulmonic closure. This can often be recognized since A2 precedes the dicrotic notch of the indirect carotid pulse trace by .03 - .04 seconds.



NORMAL MEN		SD	NORMAL WOMEN		SD
Q-2	$= -2.1 \times \text{HR} + 546$	$\pm 14$	Q-2	$= -2.0 \times \text{HR} + 549$	$\pm 14$
LVET	$= -1.7 \times \text{HR} + 413$	$\pm 10$	LVET	$= -1.6 \times \text{HR} + 418$	$\pm 10$
PEP	$= -0.4 \times \text{HR} + 133$	$\pm 13$	PEP	$= -0.4 \times \text{HR} + 131$	$\pm 11$

Determination of systolic time intervals in normal individuals in the Air Force population has given comparable results. Note that at any given heart rate, LVET is longer in adult women than in adult men.

When the observed interval is expressed as a percent of the interval predicted by the regression equation, the final expression represents a rate corrected systolic time interval. This allows comparison of a given individual with a normal population irrespective of his heart rate at the time of the determination.

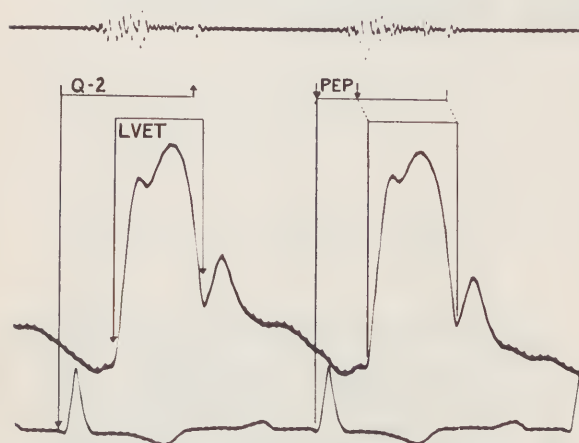


Figure 1: Determination of Q-2, LVET, and PEP. The phonocardiogram is recorded at the top, carotid pulse in the middle, and ECG at bottom. The cardiac cycle at the left shows that Q-2 is measured from the Q wave in the ECG to the first high frequency component of S2. LVET begins at the initial rapid rise of the carotid pulse and ends at the trough of the diastolic notch. The cardiac cycle at the right illustrates PEP as the difference between Q-2 and LVET. Paper speed: 150 mm/sec.

Physiologic studies indicate that the duration of LVET reflects predominantly stroke volume.<sup>6</sup> Outflow resistance also plays a role. LVET is increased by infusion of methoxamine (a peripheral arterial constrictor) as well as by obstruction at the aortic valve.<sup>1, 7-8</sup>

In normal animals, the duration of PEP correlates closely with the rate of rise of left ventricular pressure (LV dp/dt).<sup>6</sup> Aortic diastolic pressure is also important since PEP is short in severe aortic insufficiency when LV dp/dt is normal and diastolic pressure is low.<sup>8</sup>

Systolic time intervals undergo well-defined

changes in several conditions. Congestive heart failure is characterized by a prolonged PEP and shortened LVET.<sup>1</sup> This presumably reflects impaired left ventricular pressure rise (decreased dp/dt) and low cardiac output (diminished stroke volume). Similar changes can be detected in acute myocardial infarction indicating the sensitivity of this technique to changes in left ventricular performance as well as its potential prognostic usefulness.<sup>9</sup>

In our experience, systolic time intervals are most sensitive to disorders of the left ventricular outflow tract.<sup>8</sup> In valvular aortic stenosis and both discrete and idiopathic hypertrophic subaortic stenosis, there is an increased resistance to left ventricular ejection and LVET is prolonged. In aortic insufficiency when cardiac output is maintained, the left ventricular stroke volume is increased. With this lesion, LVET is also prolonged. In both lesions, PEP is shortened. Our present data suggests that PEP in AS is short chiefly because of increased left ventricular dp/dt, while in AI its short duration reflects low aortic diastolic blood pressure. The influence of outflow disorders and congestive heart failure on systolic time intervals are summarized in Table I.

Table I: HEMODYNAMIC FACTORS REFLECTED BY SYSTOLIC TIME INTERVALS

	LVOD	CHF
LVET <sub>c</sub>	↑	↓
PEP <sub>c</sub>	↓	↑
LVOD = Left ventricular outflow disorder such as aortic or subaortic stenosis or aortic insufficiency, or both		
CHF = Congestive heart failure		
LVET <sub>c</sub> = Rate corrected LVET		
PEP <sub>c</sub> = Rate corrected PEP		

In the absence of other diagnostic information, systolic time intervals are most helpful if they are markedly abnormal. An LVET greater than 3 S.D. above the predicted normal mean almost certainly indicates left ventricular outflow disease while an LVET more than 3 S.D. below the normal mean strongly suggests congestive heart failure.

Not all individuals with significant left ventricular outflow disorders have a markedly prolonged LVET at rest. If, for example, severe aortic stenosis is complicated by left ventricular failure, both PEP and LVET may be normal. In such instances, the determination must be considered in light of the available clinical information. We have seen one instance where a normal LVET became significantly prolonged after successful medical treatment of



congestive failure in a patient with severe aortic stenosis.

Serial determinations of systolic time intervals provide objective information about the hemodynamic status of patients undergoing therapy for aortic valve disease without the stress of repeated catheterizations. We have studied 20 patients before and after aortic valve surgery.<sup>8</sup> In ten patients with aortic stenosis, the mean rate corrected LVET decreased from 116% to 95% after aortic valve replacement, while the PEP increased from 64% to 89% ( $P < .01$ ). In seven patients with aortic insufficiency, aortic valve replacement led to a decrease in LVET from 127% to 103% and an increase in PEP from 43% to 106% ( $P < .01$ ). Similar changes in PEP and LVET were noted after corrective surgery in three patients with subaortic stenosis. Systolic time intervals thus allow rapid bedside assessment of the hemodynamic benefits derived from successful aortic valve surgery.

Pharmacologic intervention extends the potential diagnostic value of systolic time intervals. In normal individuals, the rate corrected LVET remains unchanged with a graded infusion of epinephrine.<sup>10</sup> In contrast, patients with idiopathic hypertrophic subaortic stenosis developed a progressively prolonged rate corrected LVET with epinephrine infusion. In this group of patients, the inotropic effect of epinephrine was used to unmask or accentuate a functional disorder, which produces left ventricular outflow tract obstruction.

In summary, determination of systolic time intervals and their changes in relation to therapeutic maneuvers and pharmacologic intervention yields valuable objective diagnostic information. However, the potential uses of systolic time intervals in clinical medicine have not been fully exploited. The hemodynamic factors which they represent are only now being elucidated. To what extent they will be able to substitute for invasive means of measuring cardiac function remains to be established. At present, this bedside technique is extremely valuable for screening and following patients with objective measurements allowing optimum use of more complex facilities.

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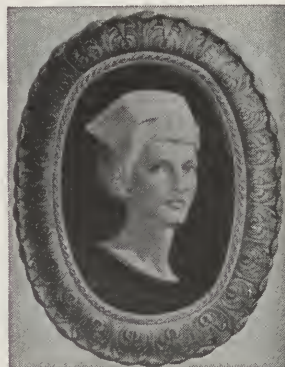
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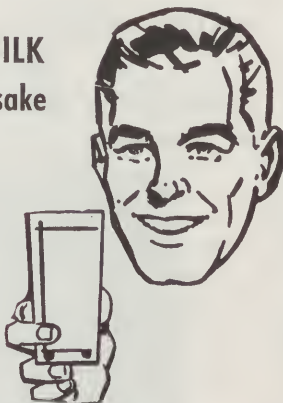


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## Baltimore City health department

# Interracial Marriages in Maryland

A statistical study of interracial marriages in Maryland has been completed by Mr. Sidney M. Norton, Director of the City Health Department's Bureau of Vital Records. It shows that abrogation of the antimiscegenation statute in Maryland in June 1967 has not resulted in any increase of statistical consequence in interracial marriages in Maryland. This study is the first and will probably be the last to be made in this area of research because of the enactment of Chapter No. 306 of State Law which removes all reference to race or color in the marriage license effective July 1, 1970.

According to Mr. Norton, interracial marriages in Maryland numbered 512 in the study period June 1, 1967 to December 31, 1968. Of these, 310 marriages were between whites and Negroes, 90 between whites and Orientals, 81 between whites and Malays, 13 between American Indians and whites, 10 between American Indians and Negroes, 6 between Negroes and Orientals, and 2 between Negroes and Malays. The total number of marriages in the state during this time was 82,993 as recorded by the Maryland State Department of Health.

Mr. Norton's study also reveals that most of the 512 marriages took place in the more populous areas of the state. In Baltimore, there were 171 interracial marriages or 33% of the total. Some 54 marriages took place in the metropolitan counties of Anne Arundel, Baltimore, Carroll, and Harford. Eighty-five marriages occurred in Elkton, Maryland, 68 in Montgomery County, and 48 in Prince George's County. Thirty-nine interracial marriages were performed in the northwestern area of the state, mostly in Hagerstown, while the remainder took place in less urban areas across the state.

In marriages between whites and Negroes, twice

as many Negro men married white women as white men married Negro women; these figures are 208 Negro grooms as compared to 102 white grooms. Oriental men married white brides more frequently than Negro brides—44 to 4, while American Indians married white and Negro brides about equally—eight white to seven Negro. White women were involved in 310 or about 60% of the marriages.

Another finding of the study was that 319 or 63% of men and women marrying interracially had never been married before. Divorced brides and grooms were second and widowers and widows were last. A total of 279 out of 481, or 58% of the marriages, included Maryland residents.

Mr. Norton's study has been published in the August 1970 issue of *Public Health Reports*, a publication of the U.S. Public Health Service. Reprints may be obtained by writing to Mr. Sidney M. Norton, Director, Bureau of Vital Records, Baltimore City Health Department, Municipal Office Building, Baltimore, Maryland 21202.

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\*Slinger, A.: Med. Times 94:150 (Feb.) 1966.

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DOUGLAS G. CARROLL, MD, EDITOR

## rehabilitation notes

# Patterns of Medical Care in a Municipal Hospital

## Intensive Care Unit: Convenience or Necessity?

DOUGLAS G. CARROLL, MD  
Baltimore City Hospitals  
Baltimore

A remarkable development in hospital practice during the 1960's was the proliferation of special units for the care of particular diseases. The rationale was to develop special facilities combining specially trained personnel together with special equipment. This movement is now represented in coronary care units, intensive care units, renal dialysis units, respiratory units, and recovery rooms. The expectation for these units is that special personnel and equipment can be better used for patient care in a small area rather than spread around a hospital. That is, it is more efficient to bring a patient to the machinery and specialists than vice-versa. There are also research and teaching advantages of such a unit.

The size of the hospital, the interest of the specialists, the willingness of practitioners to give up some responsibility for the care of their patients, along with other factors will determine how many and how well such units will develop. In some hospitals, all the above-mentioned units may be combined into a single area; others will have each of the above. Responsibility for running the unit will also

vary from hospital to hospital. In some hospitals, the surgical service will have responsibility for renal dialysis, in others the department of anesthesiology will control the intensive care unit, the respiratory unit, and the recovery room.

### Purpose of This Study

It is the purpose of this study to examine the use



of an Intensive Care Unit (ICU) by the Medical Service in a large municipal teaching hospital associated with two university medical schools where all patients are cared for by a large house staff. The hospital has a large chronic hospital where patients who have completed diagnostic studies and need prolonged treatment or observation are promptly transferred. A coronary care unit had been in operation for a year at the time this study was done. A dialysis unit was also started during the time of study.

I was particularly interested in finding out what type of patients benefited from their stay in the ICU; whether there were patients who had their lives prolonged uselessly; and whether one could differentiate these patients at the time of admission.

The ICU at the Baltimore City Hospitals (BCH) is the continuation of a respiratory care unit started in 1958 for the care of patients with respiratory paralysis of poliomyelitis. Intermittent positive pressure breathing (IPPB), principally by means of the Moersch Piston and the Bennett Respirators, has been used exclusively for artificial ventilation since 1959. Patients from all services needing intensive care are admitted to the unit and are cared for by their original service physician in consultation with other services as needed.

The Department of Anesthesiology assigns priorities to patients to be admitted. It also supplements and coordinates the activities of the other specialists. The decision to admit the patient to the ICU is made exclusively by the house staff, generally in the emergency room because most patients were admitted from this source. Medical patients admitted to the ICU were worked up by medical students and house staff and cared for by interns who also had patients

on medical wards. Patients were discharged from the ICU to the medical ward where they continued under the care of their original physician. They were discharged promptly from the ICU when it was felt that this facility was no longer of special benefit. The author saw all patients in the ICU except those who died or remained in the ICU for very short periods.

### Participants

Ninety-five medical patients were admitted to the ICU between July 4, 1968 and December 4, 1968. Medical patients who were in the ICU following surgery or who developed surgical complications were not included. The mean age was 54 years with a range of 15 to 81 and a standard deviation of 17 years.

### Charts

The information is summarized in Charts 1 and 2. In Chart 1 is listed the age (mean, standard deviation, and range); the number of patients in each group; whether it was the first, second, third, fourth, or greater hospital admission; the duration of the symptoms causing immediate admission to the hospital; the suddenness of onset of symptoms; and the source of admission (whether from the emergency room or from within the hospital).

Chart 2 shows the type of disease causing admission, the number of diseases found to be present in each patient, the time in the ICU, the results of the ICU admission (whether the patient was cured, improved or died), the number of special procedures carried out in the ICU per patient, and the complications of medical treatments for each patient.

**Chart 1. Age, number of admissions, duration of symptoms, suddenness of onset of symptoms, and source of admission of 95 medical patients admitted to an Intensive Care Unit.**

	Mean			No.	Admissions				Duration		Suddenness of Onset		Source of Adm.	
	Age	SD	Range		1	2	3	4+	Hours	Days	Hours	Days	E.R.	Hosp
<b>I. Acute CNS Depression</b>														
A. Not Requiring Intubation	32	15	(15-69)	13	11	2	0	0	13	0	13	0	13	0
B. Requiring Intubation	42	18	(20-84)	9	6	2	1	0	9	0	9	0	9	0
C. Associated with CVA	54	19	(16-81)	9	9	0	0	0	9	0	9	0	8	1
D. Metabolic	59	13	(44-76)	4	3	1	0	0	2	2	2	2	2	2
<b>II. Cardiopulmonary</b>														
A. Cardioresp. Arrest	61	11	(41-79)	18	11	3	2	2	18	0	18	0	14	4
B. Pulmonary Edema	65	9	(50-79)	11	6	3	0	2	9	2	11	0	8	3
C. Multiple Pulmonary Emboli	56	—	(47-66)	2	2	0	0	0	2	0	2	0	1	1
<b>III. Respiratory</b>														
A. Acidosis	58	6	(50-68)	8	2	2	2	2	7	1	7	1	6	2
B. Poor Toilet	63	12	(49-78)	8	5	0	0	0	3	5	5	3	5	3
<b>IV. G.I. Hemorrhage</b>	44	13	(20-54)	5	5	0	0	0	3	2	5	0	4	1
<b>V. Septicemia Shock</b>	74	—	(73-76)	2	1	0	0	1	0	2	2	0	0	2
<b>VI. Uremia</b>	56	—	(47-65)	2	1	1	0	0	0	2	0	2	0	2
<b>VII. Hyperthermia</b>	67	—	(54-80)	2	2	0	0	0	2	0	2	0	0	2
<b>VIII. Miscellaneous</b>	37	—	(32-42)	2	2	0	0	0	2	0	2	0	1	1



Chart 2: Type of diseases, number of diseases, and complications in 95 patients admitted to an ICU

		No.	Type Disease				Number Diseases				Mean Time in ICU Days	Procedure per patient	Drugs per patient	Complications per patient	Result			
			1	2	3	4	1	2	3	4+					Cure	Imp.	+	A
I	A	13	2	1	11	0	13	0	0	0	2	.4	.9	0	13	0	0	0
	B	9	0	0	9	0	8	1	0	0	1	1.8	.7	.6	9	0	0	0
	C	9	0	0	0	9	6	2	1	0	3	2.3	3.4	.1	0	1	8	7
	D	4	0	1	3	0	1	0	3	0	4	3.2	3.2	.8	0	0	4	4
II	A	18	0	0	0	18	13	1	3	1	4	2.3	4.6	.8	0	3	15	7
	B	11	0	0	11	0	4	2	0	5	4	2.5	4.0	.2	0	5	6	3
	C	2	0	0	2	0	0	0	0	2	1	1.5	2.5	0	0	1	1	1
III	A	8	0	0	8	0	3	1	0	3	9	2.7	4.4	.2	0	4	4	2
	B	8	0	0	8	0	2	1	4	1	4	2.2	3.4	.4	0	1	7	4
IV		5	0	0	0	5	4	0	1	0	3	1.4	1.6	.2	0	4	1	1
V		2	0	0	2	0	0	0	0	2	2	—	—	0	0	2	0	0
VI		2	0	0	2	0	0	0	2	0	1	—	—	0	0	1	1	1
VII		2	0	0	2	0	0	0	1	1	4	—	—	0	0	2	0	0
VIII		2	0	0	2	0	1	1	0	0	5	—	—	0	0	2	0	0

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#### Diagnostic Categories

The major syndrome or diagnosis on admission to the ICU was coma (Group I) of which drug ingestion constituted the largest number of admissions. Acute cardiopulmonary problems such as cardiac and respiratory arrest, pulmonary edema, and multiple pulmonary emboli constituted Group II. Patients with chronic respiratory diseases with an acute exacerbation of acidosis were in Group III, while those with gastrointestinal hemorrhage composed Group IV. There were two patients in Group V, and they had septicemic shock. Group VI patients had uremia. Group VII patients suffered from hyperthermia and Group VIII patients had miscellaneous problems.

The diagnosis or syndrome was not the cause of admission to the ICU. There were expectations that certain procedures available in the ICU would be helpful for certain patients. In **Group IA** for example, the patients were semicomatose and were admitted to the ICU for the major purpose of close observation in case they lapsed into deeper coma and needed respiratory assistance. Group IA contains patients who did not actually require an endotracheal tube.

In **Group IB**, all patients were in deep coma and all required intubation and artificial ventilation and careful suction for removal of secretions. Thus, the indication for admission into the ICU in Group IB was coma. The immediate cause of admission to the ICU was that intubation and artificial ventilation were available in the ICU. **Group IC** consists of comatose patients with CVA. Intubation was carried out in all

patients to allow improved mechanical suction and clearing of the respiratory tract. In **Group ID**, all patients were semicomatose from diabetic acidosis or hepatic failure. One had a seizure and another was in shock at the time of admission.

In **Group IIA**, all patients were in coma; all required intubation and artificial ventilation; all were in shock; and all had cardiac and respiratory arrest. **Group IIB** consisted of patients being treated for cardiac pulmonary edema with IPPB. In **Group IIC** both patients had recurrent pulmonary emboli and were given artificial ventilation. One was in coma, both were in shock, and one was in cardiac arrest.

**Group III** consisted of patients with respiratory failure. In **Group IIIA** (Respiratory Acidosis) all patients were extremely short of breath, all were given positive pressure breathing, one was in shock, and one in cardiac arrest. In **Group IIIB** (poor respiratory toilet) two patients were short of breath. In addition, six had pneumonia. All were suctioned through an endotracheal tube.

In **Group IV**, all patients had severe gastrointestinal bleeding but none was in severe shock on arrival at the ICU. These patients were admitted mainly for observation.

The patients in **Group V** were in shock from septicemia on admission and received treatment for this condition.

In **Group VI**, both patients were uremic and were being treated for this condition; neither was comatose.

In **Group VII**, both patients were hyperthermic



and were placed in the ICU for treatment and observation of results of treatment.

Both patients in **Group VIII** were admitted for observation.

#### **Previous Hospital Admissions**

The number of previous admissions to a hospital are listed on Chart 1. Nearly all patients on **IA** and **IB** were patients who had attempted suicide with drugs. Most of them entered for the first time but there were several who had had previous admissions for suicide attempts. The number of previous admissions is some indication of the duration and severity of the patient's underlying disease. It is noted that the patients with cardiorespiratory arrest, with pulmonary edema, with respiratory acidosis, and with poor respiratory toilet, had a large number of previous admissions. Their admissions to the ICU had been for an acute complication of their underlying disease.

#### **Duration of Symptoms Requiring Admission to ICU**

In Chart 1, the duration of the disease, syndrome, symptom, or physical finding, shows that the immediate cause for admission to the ICU had persisted for only hours in the great majority of patients. Those situations which had persisted for a day or more were metabolic depression of central nervous system function, respiratory acidosis, poor respiratory toilet, and uremia. In these situations, the patient was showing poor response to treatment and it was expected that the ICU could intensify and improve treatment.

#### **Suddenness of Onset of Cause of Admission**

The great majority of patients were admitted to the ICU at the onset and sudden exacerbation of the symptom, physical finding, or laboratory finding within a few hours. The great majority of the patients had very acute diseases or acute complications of chronic diseases. It is in these situations that the ICU is best equipped.

#### **Source of Admission of Patients to the ICU**

The great majority of patients were admitted directly from the emergency room to the ICU. It is notable that all the patients with septicemic shock, uremia, and hyperthermia had been on the hospital wards prior to transfer to the ICU. A substantial number of those with metabolic, central nervous system depression, cardiorespiratory arrest, pulmonary edema, multiple pulmonary emboli, respiratory acidosis, and poor respiratory toilet had been in the hospital. One patient with a GI hemorrhage was in the hospital for thrombocytopenic purpura and was transferred to the ICU for observation for gastrointestinal bleeding.

#### **Types of Disease**

The immediate cause of admission to the ICU was looked at from the point of view of its duration and the presence or absence of morphological organ changes associated with it. It was hoped that these categories would allow a clear-cut identification of what treatment in the ICU had accomplished. Type 1 disease was an acute self-limited process in a person who had been previously well and who was expected to experience a complete return of physiological function and a normal morphological organ pathology. For example, two patients in Group IA took accidental drug overdoses. Both of these patients had no underlying disease and recovered complete physiological and morphological function.

Type 2 consisted of those diseases in which there was believed to be gradual progression of the morphological organ changes with associated physiological malfunction. An example was a subacute progressive hepatitis in a nurse who was brought to the ICU for replacement transfusions. In general, this type of patient would not be an appropriate selection for treatment in the ICU except when some special procedure might turn the tide of the disease. In this specific patient, the effort to totally replace blood was an act of desperation and was unsuccessful.

Type 3 disease was some type of exacerbation, complication, or accentuation of an underlying chronic disease. It was usually associated with physiological failure but was potentially reversible to the morphological and physiological state prior to the acute exacerbation. Examples are potentially reversible coma, pulmonary edema, electrolyte abnormalities, respiratory acidosis, poor respiratory toilet (with or without pneumonia), septicemic shock, uremia, and hyperthermia.

Type 4 disease was a symptom, physical, or laboratory finding resulting from a complication, exacerbation, or physiological failure in a patient with an underlying disease, in which one could not expect complete return of physiological function and morphological appearance to a state present prior to the acute problem. Examples of this situation are: in Group IC where a cerebral infarction was the cause of coma; in II A where a myocardial infarction was the cause of cardiac arrest; and in gastrointestinal hemorrhage which is a complication of underlying gastric ulcer disease and may not result in full morphological normality in the ulcer area when treated successfully.

It was possible to place each patient into one of these types without too much difficulty. However, a clearer definition of the types is desirable since not all patients comatose from drug ingestion escape permanent morphological changes, and not all patients with poor pulmonary toilet survive long enough to clear up their pneumonia. On the other hand, not all patients who go into cardiac arrest have mor-



phological changes nor do all patients who have gastrointestinal bleeding have evidence of ulcer scarring if seen years later. The attempt is to place patients who had potentially morphologically reversible diseases into Type 3 and those who have irreversible causes into Type 4.

### Number of Diseases

The number of significant diseases from which the patient suffers also plays a part in the decision to admit a patient to the ICU, although the type of disease is more important than the number. This data is an attempt to find all the significant diseases which contributed to the patient's admission to the ICU. Suicide attempts were considered as manifestations of depressions or psychiatric problems and were classified as a single disease.

We have divided the patients into groups on the basis of the diagnoses or syndrome which was the cause of admission. Another way of looking at the reason for admission to the ICU is to examine the procedures carried out on the patient. Thus, the ICU had unique facilities for close observation, close monitoring of patients, and certain types of treatment (such as intermittent positive pressure breathing, suction, and pulmonary toilet through an endotracheal tube). We might therefore consider cause of admission to the ICU in terms of which treatment was given to the patient. We can also decide whether the patient was admitted primarily for observation, prevention of complications, diagnosis, or treatment with one of the unique, specific forms of treatment available only in the ICU. Chart 2 shows the procedures unique to the ICU used in the treatment of the various groups of patients.

### Procedures and Drugs

Each of the following was considered a procedure: an endotracheal tube (62), tracheostomy (11), intermittent positive pressure breathing (59), a central venous catheter (16), and lavage of the stomach (31).

Each of the following was considered drug therapy: antibiotics (49), antihypertensive drugs (33), antiarrhythmia drugs (28), anticonvulsives (17), digitalis (39), diuretics (13), steroids (18), oxygen therapy (66), and blood transfusions (14).

### Iatrogenic Complications in ICU

The following situations were considered iatrogenic complications: aspiration of gastric contents (4); difficulty with an endotracheal tube or tracheostomy (9), such as obstruction, need of replacement; febrile reactions after angiograms (2); rib fractures (6); septicemia (1); acute gastric ulcers (1); infections of catheter or tubes (2); malfunction of intermittent positive pressure breathing (1); transfu-

sion reaction (1); pneumonia other than aspiration pneumonia (6); drug resistance (2); phlebitis (2); and psychiatric disturbances of major proportions (1).

### Laboratory Studies

The mean number of chemical, bacteriological, and blood gas determinations was also calculated for each group. These include tests done only while the patient was in the ICU. The great majority of these tests were done in the first two to three days after admission to the ICU. Furthermore, patients who were transferred from the hospital to the ICU had already had a number of tests done and tended to have fewer laboratory procedures performed once they reached the ICU. Those with electrolyte problems tended to have the most chemistries done. Those with blood difficulties, such as Group IV patients, tended to have a large number of hematological procedures.

Group IIIA had three times as many bacteriological studies done as any other group except ID. Patients in Groups IIIB and VI tended to be admitted from the hospital rather than the emergency room and had lower number of bacteriological tests done because they had been obtained prior to admission to the ICU. The great preponderance of blood gases were done in Groups IIIA and IIIB.

### Other Complications

Chart 2 shows that the largest number of complications occurred in Group IIIA. This number of complications tended to increase with time in the ICU. Rib fractures were a common result of chest compression for cardiac arrest.

### Evaluation of Effectiveness of ICU

Our data does not allow us to compare the accomplishment in the ICU with what would have happened had the patient not come into the ICU. Such a study of two groups of patients whose only difference is whether they went into ICU or not seems impossible at the present time. By identifying those patients who seem to have profited most in the ICU and comparing them with those who did not, we may be able to identify which patients were most appropriately admitted to the ICU.

Patients in Groups 1A and 1B, with acute central nervous system depression secondary to drug ingestion, fared best in the ICU. All 22 of these patients recovered completely from the acute episode causing admission to the ICU. The underlying depression which precipitated the suicide attempt in these patients was not cured, and was often not adequately treated. This was not a failure of the ICU but rather of the follow-up psychiatric therapy. These patients had had relatively few previous hospital admissions,



the duration of their disease was short, they were admitted directly from the emergency room, had relatively few procedures performed, and few drugs administered. Their mean age was lower than the other groups. In no other group were cures of the immediate cause of admission accomplished.

However, a number of other groups showed a large proportion of patients who improved in the ICU. For example, patients in Group IV with gastrointestinal hemorrhages showed a large proportion of patients who improved as did Groups V, VII, and VIII. In each of these groups, the purpose for admitting these patients to the ICU was largely accomplished, whether it was for observation (Group IV) or for a specific therapy as in Groups V and VII.

The groups with the highest death rates were IC, ID, IIA, IIIB. These patients tended to be elderly, to have Type 3 and 4 diseases, to have a number of different chronic associated diseases, and to require a large number of procedures and drugs in the ICU. An examination of the records of patients who died in the ICU shows that many were in desperate condition on admission to the ICU, particularly those with cardiopulmonary arrest. Many of the patients in Group IIIB with poor pulmonary toilet were elderly, had a number of different diseases, and their inability to clear their respiratory tract of secretions was a manifestation of generalized weakness and debility. A large number of this group had been having symptoms for several days when the decision was finally made to admit them to the ICU, and they were admitted as a final desperate attempt to save their lives.

From these observations, it seems clear that the young patient with an acute potentially easily reversible disease entering the ICU for specific use of some facility there, tends to benefit much more than the elderly patient with multiple diseases, multiple previous admissions, and an underlying disease which is slowly progressive.

### Critique of This Study

This series of Rehabilitation Notes is particularly

concerned with the idea of *patient benefit*. Hospitals are operated on the assumption that we help the individual patients who are admitted to the hospital. But what criteria are we to use to judge whether we have helped the patient or not? In the above study we used the criteria of mortality rate in an Intensive Care Unit as a measure of whether certain diagnostic groups of patients were helped. Assuming that all patients were admitted to the ICU with the expectation that this unit might save their lives, we are justified in using death as an indication of failure of the ICU. But at admission there were widely different views as to how much patients might be expected to benefit. No doubt most of the suicide patients who did not need intubation were admitted with the expectation that they would do well. The admission was merely a precaution to allow early treatment by intubation if this were necessary. At the other end of the scale, certain patients who had undergone cardiac and respiratory resuscitation might well have challenged the physicians' judgment as to whether they were actually alive at the time of admission or were merely having their hearts paced and their lungs artificially ventilated. It was still believed, however, that they would benefit in the ICU.

Thus, in attempting to judge whether a patient has received benefit from a certain type of care, it is essential to compare the final outcome with entrance expectations. In attempting to judge patient benefit, therefore, it might be helpful for each physician responsible for bringing the patient into the ICU to write a prediction as to what his realistic expectations are at the time of admission.

Another problem in estimating *patient benefit* is the end point used to classify the final results. In the above study, death was taken as the criteria of failure. But some of those who died might well have been better off than some of those who were discharged from the ICU only to languish in coma until their heart stopped beating. In brief, the criteria of life or death is not always a convincing criteria of patient benefit.



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## tuberculosis

# Screening Tests of Pulmonary Function

Not only will pulmonary function screening tests help the physician differentiate between heart and lung disease, but they also may be helpful in pinpointing the location and extent of regional pulmonary disease. They should never be omitted in patients with dyspnea.

Ideally, screening tests of pulmonary function should separate normal from abnormal lungs in only a few minutes with little or no discomfort to the patient. These tests should use inexpensive, portable apparatus, the operation of which requires little or no technical training. They should be free from error, should pinpoint the specific abnormality of function and its location, and should provide quantitative data.

### Useful Ventilatory Tests

**Vital Capacity and Maximal Expiratory Flow** maneuvers are two of the simplest tests which are helpful in the early detection of pulmonary and cardiopulmonary disease.

Vital capacity may be decreased in both restrictive and obstructive pulmonary disease. However, the patient with completely restrictive disease can exhale rapidly; the patient with obstructive disease cannot.

Repetition of these tests after the patient has inhaled 0.5% isoproterenol provides further information. The aerosol will partially or completely relieve the obstruction due to contraction of smooth muscle in the airways, as in the case of asthma. It will not relieve obstruction due to destructive organic disease, such as emphysema or tumor.

A relatively inexpensive portable spirometer is all that is needed. No special training is required and calculation may be made within a few minutes. So, these tests may be administered easily in the physician's office.

These simple ventilatory tests may yield values that are within normal limits in patients with some pulmonary disease, such as localized infection, carcinoma, or disease of the pulmonary circulation. So, the clinician should consider some of the more definitive screens, including a **Single-Breath Screening Test** for pulmonary diffusing capacity.

A rapid, simple, safe, painless test, it helps to detect infiltrative lung diseases, pulmonary vascular diseases, and diseases that are associated with the loss of alveolar-capillary surface area, as in the case of emphysema. It is particularly helpful in signaling abnormalities in dyspneic patients with a normal vital capacity and a normal maximal expiratory flow rate.

A decrease in pulmonary diffusing capacity may be the earliest detectable abnormality in collagen diseases, in sarcoidosis, and in industrial diseases, such as asbestosis.

The most that is required of the patient is that he retain a breath of a low, nontoxic concentration of carbon monoxide for at least ten seconds before exhaling rapidly.

However, the test does require a skilled operator and expensive equipment, including a system for de-

*J. H. Comroe, Jr., MD; and J. A. Nadel, MD, The New England Journal of Medicine, May 28, 1970, (Vol. 282, No. 22).*



livering the test gas, a spirometer, and equipment for measuring the concentrations of the expired gases. Approximately ten minutes are needed to make the measurements and calculate the results.

It is easy and safe to measure diffusing capacity repeatedly, and to evaluate therapy or spontaneous changes in the course of the disease. The test is also useful in identifying whether pulmonary capillaries are blocked.

### Heart or Lung Disease?

A common diagnostic error is to place the label of congestive heart failure on all patients with dyspnea. Properly administered, ventilatory screening tests not only aid in differentiating cardiac from pulmonary disease but also may pinpoint the location and extent of regional pulmonary disease. Therefore, all patients with dyspnea—in cardiac or pulmonary clinics—should receive pulmonary screening tests.

Screening tests now available will show whether there is normal distribution of inspired air to the airways and pulmonary alveoli, normal distribution of blood flow to the pulmonary capillaries, or normal matching of gas and blood to the pulmonary alveoli.

A **Single-Breath Oxygen Test**, for example, which analyzes nitrogen concentrations in expired gas, can tip the clinician off to abnormality in the airways or in the lung structure. Abnormal concentrations of nitrogen indicate that some regions of the lungs are filling and emptying unevenly.

A simple, rapid, painless, and harmless test, it is useful for screening large segments of the population—especially those working in dusty trades. Nitrogen concentrations are measured by a rapid electrical analyzer.

Return to normal nitrogen concentrations after the patient has inhaled isoproterenol aerosol suggests reversible airway obstruction, or asthmatic-type disease. Persistent abnormal findings suggest organic disease such as bronchitis, emphysema, or broncho-

genic carcinoma. More definitive tests are needed to determine which disease, and to locate abnormality within the lungs.

Scanning tests such as the **Single-Breath Xenon Test**, which use radioactive tracer material ( $^{133}\text{Xe}$ ), may at least pinpoint the location of larger lesions. In this test, an external stationary detector continuously records the distribution of radioactive counts during breathholding and expiration.

The test gives important information about the distribution of gas to different regions of the lungs and the rate of ventilation of these regions. It helps to locate the bullae before surgical operations.

Although the radioactive gas and special recording apparatus are expensive, the test does provide specific information quickly on a large number of patients. There is no greater exposure to radiation than from a plain chest roentgenogram. And the test is painless; no injections or blood samples are required.

### Screening: A Must

Complete pulmonary function tests should be given to every patient undergoing surgery—especially pulmonary surgery. Effective preoperative treatment of airway obstruction reduces the frequency of postoperative complications. Pulmonary function tests may also serve as useful guides to the physician in the safer use of risky diagnostic tests. They may also provide the physician with a reliable guide on the effectiveness of therapy.

Pulmonary screening tests should never be omitted in the periodic examination of workers in potentially hazardous environments.

If the hazard is inhalation of silica, the vital capacity and diffusing capacity of the lung should be tested since inhalation of silica dust may lead to development of pulmonary fibrosis. If the hazard is irritating fumes, the screening tests should be maximal expiratory flow rates and airway resistance, since some fumes (such as sulfur dioxide) produce bronchoconstriction or mucosal congestion or edema.

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## library

### R<sub>x</sub> for Libraries

The Tri-State, or Maryland, D. C., Delaware Hospital Association, met for its 30th annual conference at the Washington Hilton Hotel, Washington, D.C., December 7-9, 1970. As has been the custom for the past three years, the Baltimore Hospital Librarians Association sponsored the program entitled "Rx for Libraries" carrying out the overall conference theme: Health Care Tomorrow: People, Places and Things.

Mrs. Lorene Pita of Provident Hospital and Mrs. Elizabeth Street of the School of Nursing Library, Union Memorial Hospital, presided. The first speaker, Mrs. Clare Tedesco from the VA Medical and General Reference Library, VA, Washington, gave some very helpful suggestions about activating the small library collection as well as supplementing reference resources. Her last admonition was SEEK HELP and do not hesitate to call on larger facilities when your own are exhausted. (Incidentally, the Med-Chi Library cooperates with *all* libraries on interlibrary loans, direct reference assistance, and is immediately available by telephone to hospitals with MEDIC hookups—without cost.)

Mrs. Jane Fulcher, Medical Librarian at the Washington Hospital Center, spoke on "*Storage and Retrieval*." She explained the makeup of her library staff, which includes volunteers as well as medical secretary trainees from the Hagerstown school. The latter assist with clipping and processing articles into binders for use both on the hospital wards, in connection with specific cases, and in the library. One series she has named LATCH (Literature Attached to Chart) which explains their use. These pieces actually travel with the chart of the individual patient until the physician has finished with it or the patient has been released, whereupon the LATCH is returned to the library. These are classified and cataloged as bound items and eliminate the confusion often encountered in charging vertical file materials.

One suggestion which Mrs. Fulcher recommended was the generous use of keywords in the catalog. Time and nerves can often be spared with this technique. Mrs. Fulcher also emphasized that everyone should be concerned with increasing their scientific vocabularies in order to understand requests and medical terminology as used by the physician. Her last admonition was that we should try to emphasize the positive approach in our contacts with borrowers and staff members.

After the luncheon, Mr. John Balkema spoke on the use of audiovisual equipment, both the loop cassette type without sound and the sight and sound type meant for desk use.

Another feature was the core Medical Library Exhibit from NLM.

I also attended a lecture by Donald H. Ehat, President, Organizational Development Associates, Washington, D.C. The title of this program was "How department heads can have more time to manage". His manner of presentation was both interesting and provocative.

\* \* \*

The Med-Chi Library will add the following journals in 1971:

- Adult and child
- Annals of thoracic surgery
- Current problems in pediatrics
- Environmental health letter
- Headache
- Infection and immunity
- Journal of medical microbiology
- Maryland magazine
- Medical tribune
- SIECUS newsletter
- World meetings: U.S. and Canada
- World meetings: Outside U.S. and Canada



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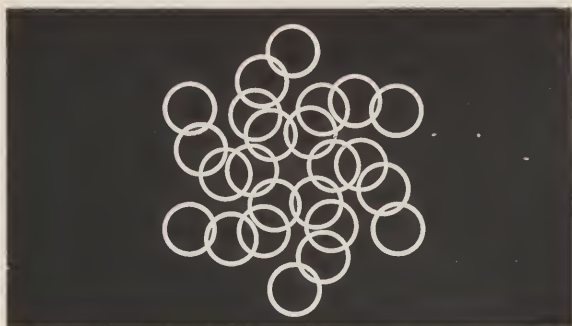
(Arranged by author and title)

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- American Medical Association. Dept. of Survey Research.  
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- American Public Health Association. Program Area Committee on Air Pollution.  
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- Beal, John Mann  
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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# Treatment of Acute Intoxication: (Part) 2

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### Barbiturate Addiction Possible

Any alcoholic who asks for barbiturates, or who either loudly or subtly protests the use of any of the other types of sedation, should not be given barbiturates. Barbiturate addiction is then suspected. This is why a qualified, conscientious physician does not have to harbor morbid fears of using tranquilizers and sedatives in the hospital management of the acute alcoholic. It is impossible to achieve maximum care without them. If the physician is at all knowledgeable and sensitive to the dangers and serious implications of addiction, this is the only way to gain any insight into the possibility of addiction already existing in the patient. If used properly, knowledgeably, and judiciously in a hospital setting, an addict is not created, but may be uncovered. A routine dose of one and one-half or three grains of one of the barbiturates is an insult to a barbiturate addict. A double dose would reveal his degree of tolerance which, then, is a more absolute proof of addiction.

The subject of paraldehyde is no longer worthy of discussion. It is an insulting routine that is extremely addictive and very unfair to the patient. That it is pharmacologically contraindicated by some experts is still controversial. One primary objection is that there is no physician capable of properly handling paraldehyde because it is frequently too effective a sedative. The most common problem with paraldehyde is that the physician only succeeds in oversedating the patient and therefore perpetuates

the pathology of prolonged anesthesia. Most likely he is dealing with a cross tolerance, and in order to achieve any kind of control, he often gives toxic doses of paraldehyde. There is some argument in favor of intramuscular paraldehyde, however, if one chooses to take a chance in giving this type of injection to a debilitated, extremely infection-prone individual. Really, the most condemning thing about the use of paraldehyde in the withdrawal of alcohol is that there has been, and still is, a direct correlation between ineffective care and the use of paraldehyde. To defend what may be the very proper and effective use of paraldehyde, is also to align oneself with a large group of very ineffective physicians and hospitals.

A drug which is not used nearly enough is chloralhydrate which, next to paraldehyde, seems to fulfill the prerequisite of affecting as closely as possible the same areas of the brain that alcohol effects. The problem with chloralhydrate is the 7½ grain concept. Fifteen to 30 grains is probably a more effective range. The drug also tends to be habit-forming. Glutethimide NF (*Doriden*) is an extremely unpredictable drug. Gastritis is one of its side effects. This drug frequently has the same synergistic toxicity we so often see with the aspirin compounds.

Probably the most neglected medication in alcohol withdrawal is intramuscular diphenylhydantoin sodium (*Dilantin*). This has an immediate anticonvulsive effect together with some tranquilizing value. It



makes an effective placebo for the patient demanding sedation, tranquilization, or analgesia. For physicians who object to placebos, this is an excellent substitute.

The most violent objection some alcoholic treatment centers have to sedation and, of course, the wide antipathy held by AA to any kind of pill is, in part, a reaction against those hospitals and physicians which have abused sedation mainly because it takes the nuisance value out of alcoholism management. This overanxious, guilt-ridden patient is usually very much benefited by the judicious use of sedatives and tranquilizers.

### **The Nurse's Responsibility**

The more diligently the nurse follows the detoxification routine, the more effective the results seem to be. This practice of placing a great deal of responsibility on the attending nurse seems to be the secret of good alcoholic recovery wards. Effective use can also be made of AA or already sober patients to reassure and calm the new patient.

The usually rigid nursing routines, where sedation is handed out like a good accountant hands out money, are to be avoided. This means the nurse has to be very perceptive and also have the right to make immediate judgments. A small dose of tranquilizers and the way in which it is administered is usually sufficient to ease the first pangs of anxiety and restlessness. If the nurse has to wait until a physician has arrived or is contacted, it invariably takes large repeated doses to accomplish the same effect. The physician who objects to standing orders and who objects to allowing a nurse some degree of judgment in the administration of tranquilizers and sedation is going to find it very difficult to manage acute alcoholism without running into a great deal of time and sometimes unnecessary difficulty. The whole thrust, of course, should be to minimize the use of tranquilizers and sedation in this extremely field-dependent type person who has already abused his liver and other organs with too much sedation.

By the same token, the nurse must be given the right to give aspirin for a headache, a laxative for constipation, antacid for an upset stomach and something for diarrhea. She must also be allowed to give the patient insulin, antihistamine, a birth control pill, or whatever has been prescribed by the referring physician prior to the patient's admission. If the nurse's judgment is questioned in these simple routines because she might be uninformed or foolish enough to give a dangerous drug, then you have been very remiss in allowing this type of ineffective person to work on the alcohol ward in the first place, and your chances of developing an effective on-going program are very poor. Experience will show that nurses do not exploit or abuse this privilege and

responsibility once they have been trained and encouraged to act.

This most illogical, deceptive person, the alcoholic, is intolerant of seeing his own faults in other people. He has been able to exist only through exploiting everything and everyone around him and has arrived at this pathetic state only through a fantastic exercise in self-deceit. He has most likely become quite ineffective and inefficient in all his actions and is quite likely compulsive, orderly, and perfectionistic to a fault. He has completely judged, condemned, and rejected himself. Therefore, he is extremely sensitive to, and violently reacts against, any of these qualities in other people. Hospital personnel, in turn, overreact to criticism from a person who appears to be so eminently unqualified to be critical of anything.

### **DT's**

With any patient diagnosed as having delirium tremens, either early, incipient, or severe, the necessity of sedation for the control of anxiety is paramount. There are also the problems of fluid balance and electrolyte control, which are best accomplished and managed by the intravenous route. This article recommends the two-bottle routine for sedation, fluid balance, electrolyte control, and replacement therapy. A usual starting dose is a 1000 cc bottle of 10% glucose and water, and a 1000 cc bottle of a 5% glucose and saline. Judging whether or not the alcoholic is hydrated or dehydrated is extremely difficult. A blood count, SMA 12, and a sodium potassium blood level should be ordered. Blood count and differential often give a picture of hydration as do some of the SM 12 scales.

The electrolyte levels are quite significant. In the meantime, 7½ grains of sodium amytal are added to the 10% glucose and water for sedative control and the various replacement ingredients are added to the 5% glucose and saline. These replacement ingredients are usually vitamin B's and measured amounts of vitamins B<sub>1</sub>, 3, 6, and 12. There are various articles adequately promoting vitamin C and regular insulin. Twenty-five units of regular insulin in the 10% glucose is at least good for the physician's morale. The already prepared ampules of multivitamins seem to be effective enough in the replacement routine. You now reassure, hydrate, mineralize, and sedate the patient into a state of natural sleep. If the patient is at all restless, the 10% glucose and water with its added sedative is given. If the patient goes to sleep, the sedation is immediately stopped and the 5% glucose and saline with the added vitamins is started. As soon as the patient becomes restless again, the switch is repeated. As your lab work comes in, you can use any combination of the routinely prepared intravenous fluids,



10% glucose and water, 5% glucose and water, the various glucose and salines, and the isotonic ringer solutions. You add the various electrolytes as the lab levels indicate. The most significant factor seems to be not only relieving the continued tension state of the alcoholic, but also carefully avoiding oversedation.

### **Cortical Extracts Questionable**

The use of cortical extracts in the management of DT's is still questionable. It adds another complication to an already complicated situation and seems quite ineffective in most cases. However, it has proved effective in those cases of DT's that complicate emergency surgery. This has to be carefully agreed to by the surgeon because of the fear that it may interfere with the very necessary postoperative healing processes.

Cortisone has not been as equally effective in those cases involving other medical complications such as pneumonia, exfoliative dermatitis, gangrene, frostbite, and multiple injuries.

The whole area of detoxifying or managing a DT patient with other medical problems, such as congestive heart failure, coronary occlusion, respiratory disasters, renal complication and, of course, the common scourges such as gastric intestinal hemorrhage, diabetes, and acute pancreatitis can become unnecessarily involved. The rules of the road usually are to give precedence to the consultant. If the cardiologist calls in an alcohol expert, he gives precedence to his management, and the converse is also true. This does not necessarily work out very well. The routines are not always complimentary, and priorities must be agreed upon and established. This is not a peculiar phenomenon to alcoholism. It occurs in all multiple medical calamities, and effective compromises must be established. It usually means that the precautionary routines of both regimes are accented. DT's occurring in a fragile diabetic is much more difficult to control and, obviously, diabetes is much more difficult to treat in an alcoholic.

There has been a tendency to overtreat the medical complications that occur in acute alcoholism, such as prescribing antibiotics for elevated temperature before any infectious process is defined or located. Elevated temperature, of course, is one of the discouraging signs of terminal DT's, so there is a historical significance to this sense of urgency.

The lack of history and the high possibility of injury, medical complications, and long-time neglect often encourage an unusual amount of lab procedures, X-ray, consultation and examination. These procedures are requested in spite of the fact that the goal of rest and relaxation is primary and a minimal amount of sensory stimulation is beneficial in the case of established DT's.

Nevertheless, early consultation is very helpful in managing DT's. An undetected fracture or dislocation, a severe puritis, painful cystitis, incipient congestive failure, or diabetes make DT's much more difficult to resolve. The violence of the DT's scares anyone and, eventually, even the most experienced medical crews. The reassurance of a cardiologist or the skilled recommendation of an orthoped or dermatologist can greatly reassure the detoxifying staff and this, in turn, will be reflected in their continued management of the patient.

We encourage the judicious use of IV fluids before the actual hydration status is established. The dehydration that results from severe diaphoreses is very difficult to keep pace with, whereas the overhydration that immediate IV may cause seems an easier situation to remedy.

In spite of the fact that a DT patient is actively hallucinating and is quite disoriented, he still retains a great dread of incontinence. Sometimes an extremely restless DT patient will quickly relax with the insertion of a Foley. We recommend this, even though there is the possibility of infection and even trauma from the retention catheter. Likewise, bathroom privileges are often less traumatic to the congestive failure that may be complicating DT's than insisting on the patient's use of a bedpan. Alcoholics have an insoluble antipathy to bedpans.

Most certainly, the goal of any good treatment regime is not just a short detoxifying period, but also a rehabilitating program. The patient should leave the hospital without either tranquilizer or sedative. These patients classically do better than those who leave with new crutches. A recent followup at Lutheran General Hospital gave strong support to this statement. The obviously "recovered" group were discharged without drugs and were using far fewer medications than the "failure" group.

### **Conclusion**

It is quite obvious that this article contains no unusual information or techniques. There is no new and unusual information on the management of the acute alcoholic. However, knowledge and routines available are quite adequate. Nevertheless, hospitals still frequently make the claim that they find alcoholics unmanageable. The primary problem seems to be the inexperience and staff attitudes. When that situation is corrected and adequate amounts of sedatives or tranquilizers are used, the alcoholic is a very manageable patient. The only difference in the treatment of medical complications together with the acute intoxication is that it possibly requires more vigor and dispatch. A hospital or ward team dedicated to the treatment of the disease of alcoholism will find the management of acute alcohol emergencies no more difficult and just as challenging as any other medical emergency.



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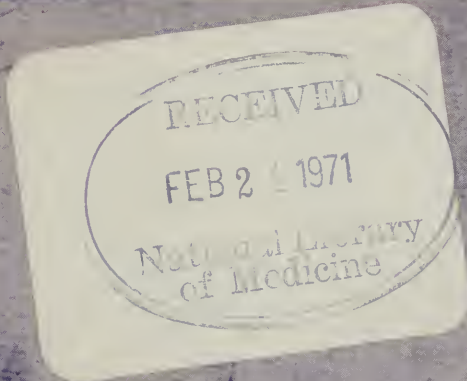
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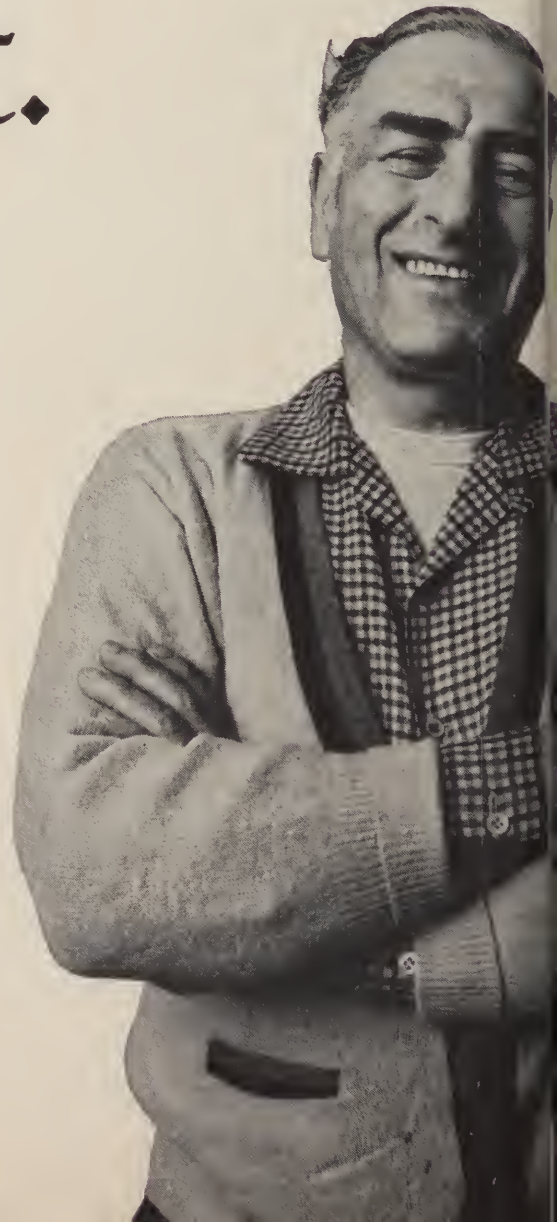
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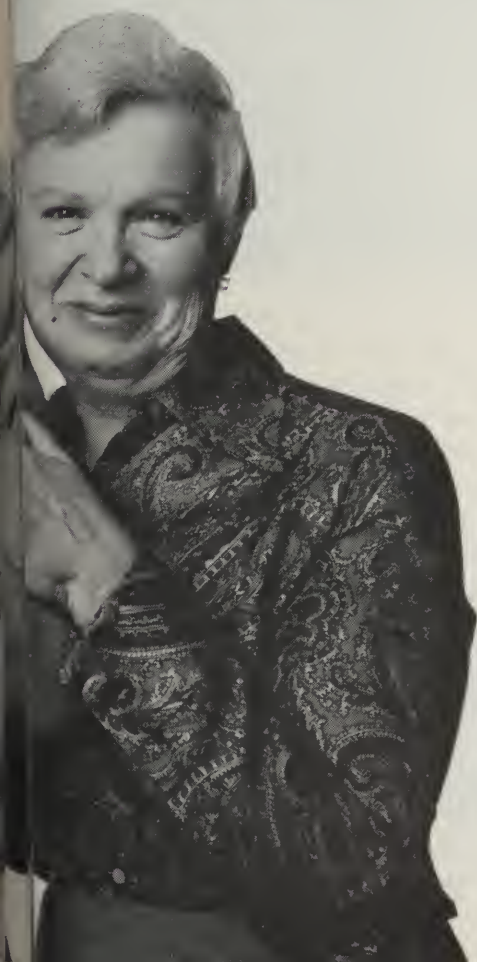




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**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

**Precautions:** In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

**Adverse Reactions:** Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

**Usual Dosage:** One tablet t.i.d. for 21 days, followed by one-week rest periods.

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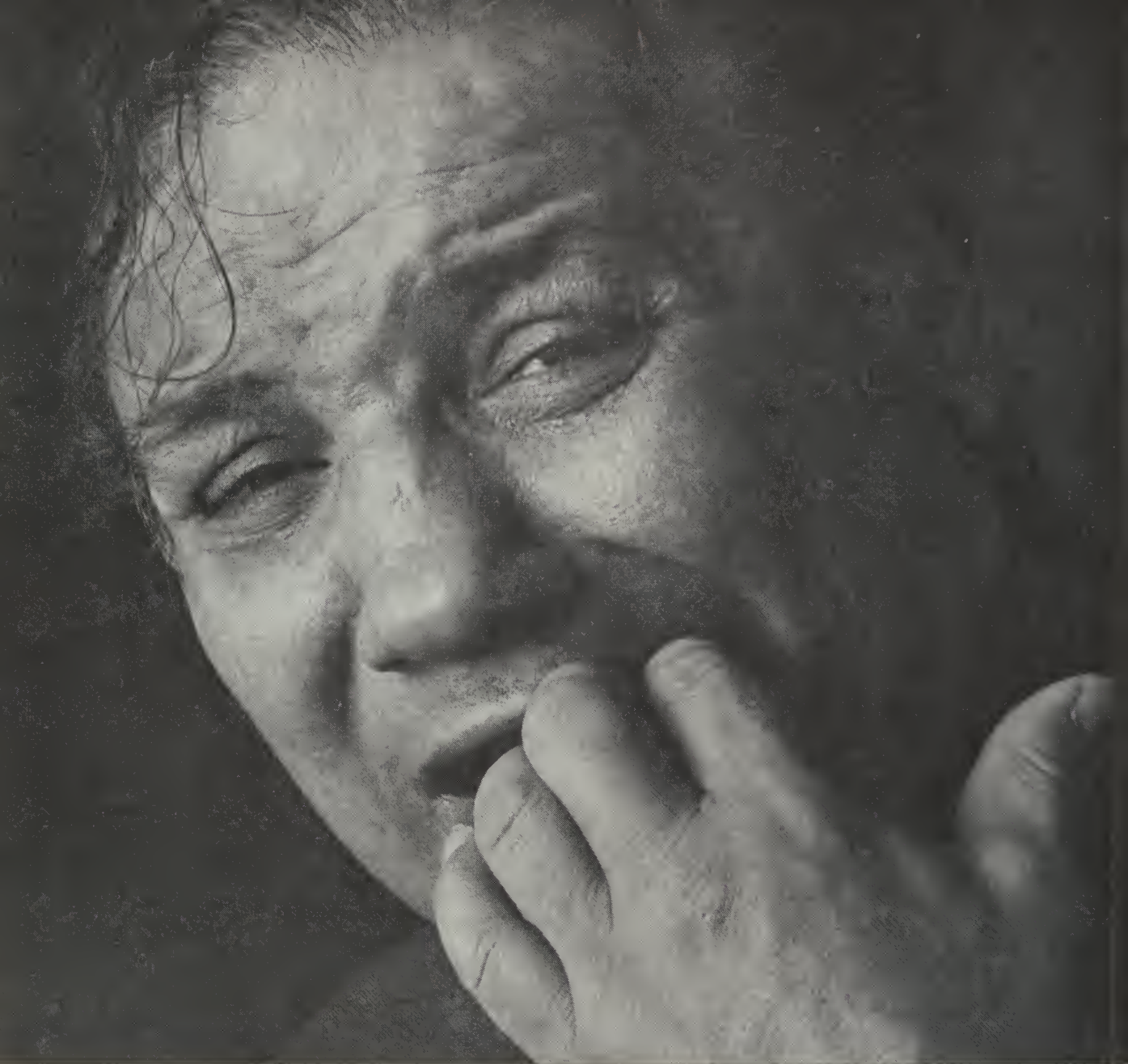
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# maryland state MEDICAL JOURNAL

VOLUME 20

FEBRUARY 1971

NUMBER 2

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"As pioneers in respiratory care, we must travel a long distance, fighting many problems, and wrestling with many issues in pulmonary disease. It is very probable that we are now in a transition state, the benefactors of many technical developments, but most of these unproven and many still to come. Nevertheless, progress in respiratory care is occurring and a common framework within which respiratory care improves and grows is developing."

### Medicine in Maryland, 1634 to 1835, Douglas G. Carroll, MD . . . . 59

"In a study of the medical history of Maryland, three important philosophical attitudes can be identified, emerging at different historical periods. An understanding of these ideas will illumine contemporary medical practice and hopefully will be helpful in molding the future. These ideas may be epitomized in the lives of individual physicians, in the establishment of certain medical organizations, and in the development of a new methodology. Far from being mutually exclusive, each new idea could be built only on the foundation of the previous idea. Furthermore, each of these ideas is incorporated more or less into present day medical thought."

### Maryland Faces the 1970's, Kurt Gorwitz, ScD, Francis Jean Warthen, PhD . . . . . 64

"Theodore R. McKeldin, Maryland's former governor, has referred to the state as 'America in Miniature'. This description is quite apt, since its geography, together with its population composition, characteristics, and distribution are a microcosm of the total United States. We will present and analyze statistics related to the state's health problems and consider some of the issues facing the state in the years ahead. While numbers and place names may differ, these problems and issues are comparable to those existing in many other states. As such, implications of the facts considered here transcend Maryland's boundaries."

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# Doctors take note...

**FEBRUARY 17-19, 1971**

**AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Medical Complications in Pregnancy: Ambassador Hotel, 3400 Wilshire Blvd., Los Angeles, Calif. Contact: Phil R. Manning, MD, FACP, or Edward J. Quilligan, MD, Co-directors, University of Southern California, Los Angeles, California.

**FEBRUARY 18-20, 1971**

**UNIVERSITY OF UTAH COLLEGE OF MEDICINE/AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

12th Annual Obstetrics and Gynecology Course: Park City, Utah. Contact: Postgraduate Medical Education Section, Department of Community and Family Medicine, University of Utah College of Medicine, 50 North Medical Drive, Salt Lake City, Utah 84112.

**FEBRUARY 18-24, 1971**

**MARQUETTE SCHOOL OF MEDICINE**

4th Annual Postgraduate Course in Gynecological Pathology, Cytogenics, and Endocrinology: Pfister Hotel, Milwaukee, Wisconsin. Contact: Richard F. Mattingly, MD, Professor and Chairman, Department of Gynecology and Obstetrics, 8700 W. Wisconsin Ave., Milwaukee, Wisconsin 53226.

**FEBRUARY 20-21, 1971**

**AMERICAN ACADEMY OF ALLERGY**

Postgraduate Course—27th Annual Meeting: Palmer House, Chicago, Illinois. Arthur M. Silverstein, MD, of the Wilmer Ophthalmological Institute of The Johns Hopkins University School of Medicine, Baltimore, Md., will participate in the session on New Developments in Cellular Immunology. Contact: American Academy of Allergy, 756 N. Milwaukee St., Milwaukee, Wisc. 53202.

**FEBRUARY 20-27, 1971**

**AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS/COLLEGE OF AMERICAN PATHOLOGISTS**

Joint Interim Meeting: The Dunes, Las Vegas, Nevada. Contact: The American Society of Clinical Pathologists, The Secretariat, 710 South Wolcott Avenue, Chicago, Ill. 60612.

**FEBRUARY 21-26, 1971**

**AMERICAN ACADEMY OF FORENSIC SCIENCES**

23rd Annual Program: Phoenix, Arizona. Contact: American Academy of Forensic Sciences, 750 Main Street, Suite 1000, Hartford, Conn. 06103.

**FEBRUARY 1971**



**FEBRUARY 22-26, 1971**

**AMERICAN COLLEGE OF SURGEONS**

5th International Congress of Plastic and Reconstructive Surgery: Melbourne, Australia. Contact: American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

**FEBRUARY 25-26, 1971**

**STROKE PROJECT, DEPARTMENT OF REHABILITATION MEDICINE, SINAI HOSPITAL OF BALTIMORE/  
MARYLAND REGIONAL MEDICAL PROGRAM**

Seminar—New Directions in Vocational Rehabilitation: The Stroke Patient: Belvedere Hotel, Charles and Chase Sts., Baltimore, Md. For additional information, contact: Stroke Office, Department of Rehabilitation Medicine, Sinai Hospital of Baltimore, Baltimore, Md. 21215.

**MARCH 1-2, 1971**

**NEW YORK UNIVERSITY MEDICAL CENTER**

Course—Rehabilitation in Chronic Lung Diseases: New York, N.Y. Contact: Edward H. Bergofsky, MD, NYU Institute of Rehabilitation Medicine, 400 East 34th St., New York, N.Y. 10016.

**MARCH 1-5, 1971**

**NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL**

Symposium on Arthritis and Related Disorders: New York University Postgraduate Medical School, 550 First Ave., New York, New York. The symposium is designed for physicians and researchers seeking detailed knowledge of many forms of arthritis, rheumatic fever, systemic lupus erythematosus, gout, and streptococcal infections. Fee: \$150. Contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N. Y. 10016.

**MARCH 1-6, 1971**

**SOCIETY FOR CRYOSURGERY**

Meeting: Diplomat Hotel and Country Club, Hollywood, Florida. Contact: Mary Trueblood, Secretary, Society for Cryosurgery, 300 N. Michigan Ave., Chicago, Ill. 60602.

**MARCH 3-12, 1971**

**CONTINENTAL DENTAL-MEDICAL ASSOCIATION**

Meeting: Chamonix, France & St. Moritz, Switzerland. Leaves from Friendship Airport. Contact: Stanley Kogan, MD, Secretary-Treasurer, 6810 Park Heights Ave., Baltimore, Md. 21215.

**MARCH 4-5, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Gynecologic Endoscopy: Livingston, New Jersey. Topics include anesthesia, instruments, complications and operative culdoscopy, and peritoneoscopy. Films will also be included in the program. Contact: James L. Breen, MD, Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, New Jersey 07039.

**MARCH 4-6, 1971**

**SOCIETY FOR CONTEMPORARY OPHTHALMOLOGY**

1st Annual Meeting: Diplomat Hotel and Country Club, Hollywood, Florida. Contact: Society for Contemporary Ophthalmology, 30 North Michigan Ave., Room 1629, Chicago, Ill. 60602.

*(Continued on page 52)*



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# executive director's newsletter

February, 1971

## LONDON TRIP

Arrangements have been completed for a seven-day trip to London, England, direct from Friendship Airport, May 16-23, via Air India. Included in the total price are side trips to Stonehenge, Cambridge, Winchester, and Bath. Dinners at the Churchill Club and other exclusive eating places, as well as theater tickets for plays of your choice are also included. Deluxe hotel accommodations will be provided.

Reservations should be made through Mrs. Wolins of the Travel Guide Agency, 416 North Charles Street, Telephone Sa-7-1696. A \$50 deposit is required on the total cost of \$369.

## USPHS HEALTH SURVEY

From March 1 through April 15, some 400 to 600 persons will be evaluated by the USPHS concerning health conditions. Similar to previous surveys, residents of Carroll and Baltimore counties and Baltimore city will be selected at random for this study. Reports will be sent to the patient's own physician. This year's survey, unlike previous surveys, will include a nutrition evaluation of certain patients examined.

## DID YOU KNOW. . .

less than one third of U.S. workers are covered by unions?

## LEGISLATURE CONVENES

The General Assembly convened on January 13, 1971, for its first 90-day session in several years. Seventy-day sessions have been the order of business for the past four years. Before that, the Legislature convened on an alternate 30- and 90-day session.

The first issue of The Assemblyman has been mailed to all Faculty members and contains information on the Faculty's Legislature program as well as those health or health-related bills that are expected to be introduced during the session.

The Faculty will again staff the first aid room during the session, and the Maryland Academy of Family Practice plans to have a physician on duty during the last several weeks.

Physicians from the Anne Arundel County Medical Society will be on call at all times. The Anne Arundel General Hospital is also providing drugs and equipment for use in the room.



IF YOU  
DON'T KNOW . . .

the reasons for denial of Medicare benefits for non-covered services for patients while hospitalized, plan to attend the session scheduled for Thursday, February 18, 1971, at 8 PM in the Faculty building.

The session will have as guest speaker Theodore C. Bedwell, MD, Chief Medical Officer, of the Social Security Administration. Questions and answers will follow the panel presentations, which include comments by Emmett J. Queen, MD, Medical Director of Maryland Blue Cross; and Reginald H. Dabney, President, Maryland Blue Cross

IMPORTANT  
DATES  
TO  
REMEMBER

Important dates to remember in the next few months:

February 18: Evening sessions on utilization in hospitals under Medicare rules; 8 PM to 10 PM, in the Faculty building.

March 31: All-day session on Practical Emergency Department Service.

May 12-14: MED-CHI'S ANNUAL MEETING at the Baltimore Civic Center. See page 26 of this Journal for further information.

September 15-19: MED-CHI'S SEMIANNUAL MEETING. The Scientific Session will be held in Las Croabas, Puerto Rico. See page 49 for more information and reservation form.

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PHYSICIANS

More and more cases are being brought to the attention of the Faculty's Mediation Committee which involve advertising or solicitation by physicians. Such practices are in violation of the Medical Practice Act and the Regulations of the Board of Medical Examiners.

The committee is viewing these violations seriously whether they are intentional or unintentional and plan appropriate disciplinary action where warranted.

  
Executive Director



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**WEDNESDAY, MARCH 31, 1971**

An important date on which all physicians and allied medical personnel are invited to attend a symposium on

**PRACTICAL EMERGENCY DEPARTMENT SERVICE**

An all-day symposium will be sponsored by the Medical and Chirurgical Faculty of Maryland at the  
**St. Joseph Hospital, Towson, Maryland**

**9:30 AM — 11:15 AM**

WHO CARES WHO CARRIES YOUR PATIENT?

EQUIPMENT: THE GOOD AND THE DANGEROUS

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EMERGENCY ATTENDANTS DO NEED MORE TRAINING THAN BARBER SURGEONS!

**Perry Stearns, MD**, Assistant Commissioner, Community Health Services, Department of Health and Mental Hygiene of Maryland

CERTIFICATION: HOW TO DO IT EFFECTIVELY

**James D. Carr, MD**, Assistant Commissioner for Local Health Services, Baltimore City Health Department

HOW TO COORDINATE EMERGENCY SERVICES

**Battalion Chief Martin C. McMahon**, Baltimore City Fire Department

SPECIAL RIDES FOR SPECIAL PATIENTS

**R Adams Cowley, MD**, Program Director, Center for the Study of Trauma, University of Maryland School of Medicine

**11:15 AM — 11:30 AM**

INTERMISSION

Coffee and soft drinks will be served

**11:30 AM — 1:00 PM**

CAN YOU FUNCTION WITH JUST ANY STAFF?

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**Joseph Berman, MD, MPH**, Chief of Community Medicine, Sinai Hospital of Baltimore

THE PRACTICALITY OF A FULLY PRIVATE STAFF

Speaker to be announced, Emergency Room Physicians, Inc., St. Agnes Hospital, Baltimore

**1:00 PM — 2:00 PM**

LUNCH

Courtesy of St. Joseph Hospital, Towson, Maryland

**2:00 PM — 3:00 PM**

HOW TO MANAGE CRITICAL EMOTIONAL STATES—24 HOURS A DAY

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The Sheppard and Enoch Pratt Hospital, Towson, Maryland

**Robert W. Gibson, MD**, Medical Director

**Kent E. Robinson, MD**, Director, Outpatient Services

**Arthur N. Hildreth, MD**, Staff Psychiatrist

**3:00 PM — 3:15 PM**

INTERMISSION

Coffee and soft drinks will be served

**3:15 PM — 4:00 PM**

CRYPTIC CRISES

**Leon J. Taubenhaus, MD**, Chief of Community Medicine, Beekman-Downtown Hospital, New York city

**4:00 PM — 4:45 PM**

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**PLAN TO ATTEND—WEDNESDAY, MARCH 31, 1971—ST. JOSEPH HOSPITAL, TOWSON**

-----  
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**Thomas A. Otter, MD**

Assistant Resident in Orthopedic Surgery  
Johns Hopkins University School of Medicine

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Replays: Monday, February 22, 1971 12:30 PM  
Wednesday, February 24, 1971 7:30 AM  
9:00 AM  
2:00 PM

**FEBRUARY 26, 1971 — 12:30 PM**

## **L-DOPA AND PARKINSONISM**

**William O'Malley, MD**

Director of Research at Parke-Davis on L-Dopa  
Ann Arbor, Michigan

**SPONSOR: FREDERICK MEMORIAL HOSPITAL**

Replays: Monday, March 1, 1971 12:30 PM  
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9:00 AM  
2:00 PM

**MARCH 3, 1971 — 12:30 PM**

## **ILEOSTOMY AND COLOSTOMY MANAGEMENT**

**Marvin M. Schuster, MD**

Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

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Replays: Friday, March 5, 1971 12:30 PM  
Monday, March 8, 1971 12:30 PM  
Wednesday, March 10, 1971 7:30 AM  
9:00 AM  
2:00 PM

**MARCH 12, 1971 — 12:30 PM**

## **PRE-HOSPITAL MANAGEMENT OF MYOCARDIAL INFARCTION**

**Leonard Scherlis, MD**

Professor of Medicine and Head,  
Division of Cardiology  
University of Maryland School of Medicine

**SPONSOR: ST. AGNES HOSPITAL**

Replays: Monday, March 15, 1971 12:30 PM  
Wednesday, March 17, 1971 7:30 AM  
9:00 AM  
2:00 PM

**MARCH 19, 1971 — 12:30 PM**

## **ALLERGIES AND ANAPHYLACTIC REACTIONS**

**Philip S. Norman, MD**

Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**SPONSOR: BALTIMORE CITY HOSPITALS**

Replays: Monday, March 22, 1971 12:30 PM  
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---

### **CONTINUING PROGRAMS**

---

(Heard at participating hospitals only)

**TUESDAY MORNINGS — 11:30 AM**

**MEDICAL GRAND ROUNDS**  
University of Maryland Hospital

**WEDNESDAYS — 12 NOON**

**C. P. C.**  
The Johns Hopkins Hospital

**SATURDAY MORNINGS — 8:00 AM**

**PEDIATRIC GRAND ROUNDS**  
The Johns Hopkins Hospital

**SATURDAY MORNINGS — 10:00 AM**

**MEDICAL GRAND ROUNDS**  
The Johns Hopkins Hospital



## MEDIC . . .

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### SPECIAL INTEREST PROGRAMS

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March 23      April 27      May 25

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Easton Memorial, Easton  
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Frederick Memorial, Frederick  
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St. Agnes, Baltimore  
St. Joseph, Baltimore  
St. Mary's, Leonardtown  
Sinai, Baltimore  
Union Hospital of Cecil County, Elkton  
Union Memorial, Baltimore  
University of Maryland, Baltimore  
Veterans Administration, Loch Raven, Baltimore  
Washington County, Hagerstown

**Other locations:**

Baltimore County Health Dept., Towson  
Civil Defense Headquarters, Baltimore  
Hospital Council of Maryland, Inc., Baltimore  
Medical and Chirurgical Faculty, Baltimore  
State Department of Health, Baltimore

**For further information contact:**

Medical and Chirurgical Faculty of the State of Maryland  
1211 Cathedral Street, Baltimore, Maryland 21201  
(301) 539-0872

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State Department of Health, 301 W. Preston Street  
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**NOTE:** Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

**Contraindications:** Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

**Warnings:** May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

**Precautions:** When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be aggravated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as phenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

**Adverse Reactions:** *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction. **How Supplied:** Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

For more detailed information, consult your MSD representative or see the *Direction Circular*. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

when the diagnosis is depression

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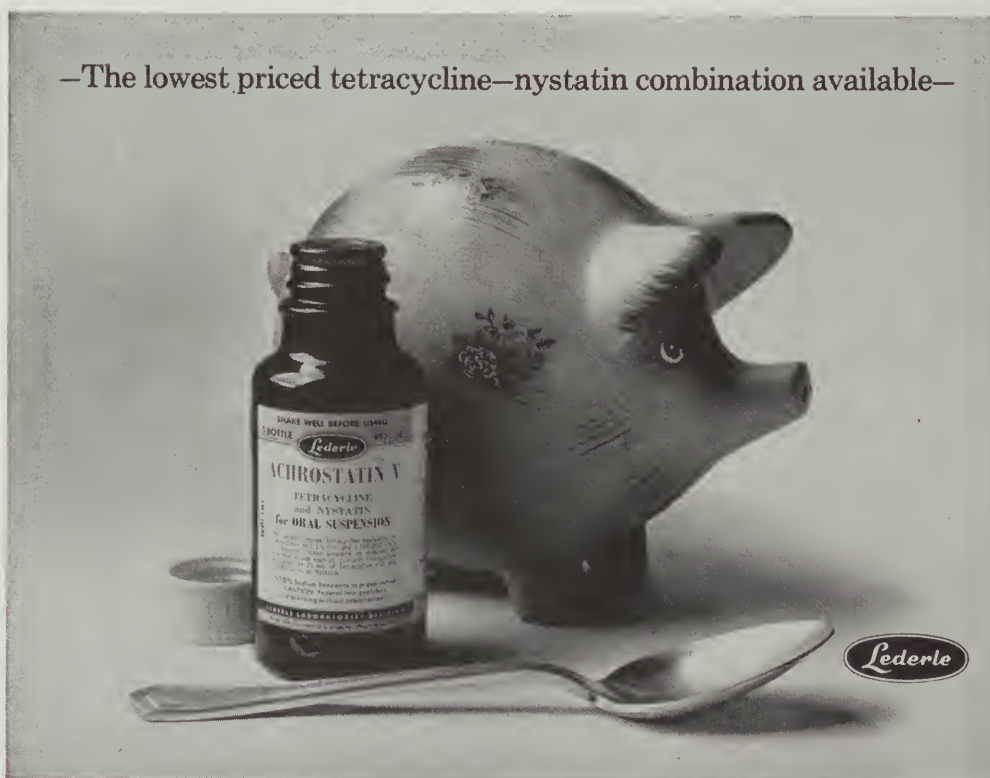
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Larobec provides: B-complex vitamins, of particular importance to the patient who is on levodopa therapy and is deficient in water-soluble vitamins.

Larobec provides: Ascorbic acid, useful in assisting tissue repair in the debilitated patient.



Larobec does *not* provide: Pyridoxine (vitamin B<sub>6</sub>)—which reportedly reverses the antiparkinson effects of levodopa therapy.<sup>1,2</sup>

## Larobec<sup>T.M.</sup> Tablets

A high-potency nutritional supplement specific to the needs of patients with Parkinson's disease and syndrome on levodopa therapy—that describes new Larobec<sup>T.M.</sup> from Roche. Larobec provides the major B vitamins plus vitamin C—but *does not provide pyridoxine*. Thus, with its specially tailored formula, Larobec assures the patient important nutritional support without minimizing any of the benefits of levodopa therapy.

1. Duvoisin, R. C.; Yahr, M.D., and Coté, L. D.: *Trans. Amer. Neurol. Assoc.*, 94:81, 1969.
2. Cotzias, G. C.: *J.A.M.A.*, 210:1255, 1969.



#### Complete Prescribing Information:

Each Larobec tablet contains:

Thiamine mononitrate (vitamin B<sub>1</sub>) 15 mg  
Riboflavin (vitamin B<sub>2</sub>) ..... 15 mg  
Niacinamide ..... 100 mg  
Calcium pantothenate ..... 20 mg  
Cyanocobalamin (vitamin B<sub>12</sub>) ... 5 mcg  
Folic acid ..... 0.5 mg  
Ascorbic acid (vitamin C) ..... 500 mg

**Description:** For prophylactic or therapeutic nutritional supplementation concomitant with levodopa therapy in patients with Parkinson's disease and syndrome, Larobec provides high potency dosages of the major B-complex vitamins, without pyridoxine (vitamin B<sub>6</sub>) which has been reported<sup>1,2</sup> to reduce the clinical benefits of levodopa therapy. B-complex vitamins are essential in the anabolism of carbohydrate and protein and in hematopoiesis. Larobec also contains therapeutic quantities of ascorbic acid, a substance involved in intracellular reactions such as tissue repair and collagen formation.

**Indications:** Larobec is indicated for supportive nutritional supplementation when a water-soluble vitamin formula (without pyridoxine) is required prophylactically or therapeutically in patients under treatment with levodopa.

**Warning:** Administration of vitamin B<sub>6</sub> may be required if signs of pyridoxine deficiency develop. Larobec is not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B<sub>12</sub>.

**Dosage and Administration:** One or two tablets daily, as indicated by clinical need.

**How Supplied:** Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.

#### References:

1. Duvoisin, R. C., et al.: *Trans. Amer. Neurol. Assoc.*, 94: 81, 1969.
2. Cotzias, G. C.: *J.A.M.A.*, 210:1255, 1969.

high-potency  
nutritional support for  
the levodopa patient

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# ART AND HOBBY EXHIBIT

## Annual Meeting of the Medical and Chirurgical Faculty

### MAY 12, 13, 14, 1971      Baltimore Civic Center

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#### APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....
  2. Amount of space required—depth, width, and height: .....
  3. Electrical or other requirements: .....
  4. Name of exhibitor: .....  
Please print
  5. Address of exhibitor: .....
  6. Telephone number of exhibitor: .....
- 

An Art and Hobby Exhibit will be held during the 173rd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to the Baltimore Civic Center, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, May 11, 1971. They must be removed on Friday, May 14, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.

A Hobby Corner at the Semiannual Meeting of the Faculty in Hershey created a great deal of interest. LET'S MAKE IT A REAL "SHOW" FOR THE 1971 ANNUAL MEETING. SUBMIT YOUR ENTRIES NOW!





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# NEW DIMENSIONS IN MEDICINE

## 173rd ANNUAL MEETING

of the

Medical and Chirurgical Faculty of Maryland

MAY 12, 13, 14, 1971

BALTIMORE CIVIC CENTER, BALTIMORE, MARYLAND

Presenting papers during the Annual Meeting will be:

**Alan F. Guttmacher, MD**

President  
Planned Parenthood-World Population  
The Hundley Memorial Lecture in Gynecology

**G. Rainey Williams, MD**

Professor of Surgery and Chairman  
Department of Surgery  
University of Oklahoma Medical Center  
The J. M. T. Finney Fund Lecture

**George E. Schreiner, MD**

Director of Nephrology Division  
Department of Medicine  
Georgetown University School of Medicine  
The Albert E. Goldstein Memorial Lecture

**Saul Krugman, MD**

Professor and Chairman  
Department of Pediatrics  
New York University  
Harvey Grant Beck Memorial Lecture

**Lawrence K. Pickett, MD**

Professor of Pediatric Surgery and Pediatrics  
Yale University School of Medicine  
The I. Ridgeway Trimble Fund Lecture

**Nicholas J. Pisacano, MD**

Secretary  
American Board of Family Practice, Inc.  
Head  
Department of Family Practice  
University of Kentucky School of Medicine  
The George M. Boyer, MD, Lecture

**Edward C. Rosenow, Jr., MD**

Executive Director  
American College of Physicians  
The Amos R. Koontz Memorial Lecture

**Neil L. Chayet, Esquire**

Boston, Massachusetts  
The Jesse C. Coggins Fund Lecture



**MEDICAL PEDIATRIC GRAND ROUNDS**, conducted by Marvin Cornblath, MD, Professor and Head, Department of Pediatrics, University of Maryland School of Medicine, will follow the talk given by Saul Krugman, MD, on Thursday morning, May 13.

**SURGICAL PEDIATRIC GRAND ROUNDS**, conducted by J. Alex Haller, Jr., MD, Robert Garrett Professor of Pediatric Surgery, The Johns Hopkins University School of Medicine, will follow the talk given by Lawrence K. Pickett, MD, on Thursday afternoon, May 13.

**PANEL-SYMPOSIUM** on *Treatment of the Alcoholic and the Family: Practical Aspects*, conducted by Martin L. Singewald, MD, Chairman of the Committee on Medicine and Religion of the Medical and Chirurgical Faculty, has been scheduled for Wednesday evening, May 12.

#### **SCIENTIFIC AND TECHNICAL EXHIBITS**

Many exhibits, both technical and scientific, will be on display at the Baltimore Civic Center all during the Annual Meeting. **SEE THESE EXHIBITS AND KEEP ABREAST OF SCIENTIFIC ADVANCEMENT!**

All physicians who have a scientific exhibit are invited to submit an application. See page 46 of this Journal for the form.

#### **OTHER ANNUAL MEETING ACTIVITIES**

**ROUND TABLE LUNCHEON**—catered at the Baltimore Civic Center.  
Various subjects of interest to all physicians will be discussed.

**HOSPITALITY NIGHT** at the Baltimore Hilton Hotel. A fun function for all!

**PRESIDENTIAL RECEPTION AND BANQUET**—a dinner dance at the Blue Crest North.  
This will be an affair long to be remembered by all who attend.

**ART AND HOBBY EXHIBIT** at the Baltimore Civic Center. All physicians, their wives, and families are invited to complete and send to the Faculty office the application on page 24 of this Journal.

**BUSINESS MEETINGS**—Wednesday morning, May 12, and Friday afternoon, May 14.

**MORE DETAILS LATER —**

**BUT MARK THESE DATES ON YOUR CALENDAR NOW**

**MAY 12, 13, 14, 1971**

Arlie R. Mansberger, Jr., MD, *Chairman*  
Committee on Program and Arrangements



# MORE ABOUT THE SPEAKERS

## for the Faculty's

### 173rd ANNUAL MEETING

MAY 12, 13, 14, 1971

On Wednesday afternoon, May 12, the J. M. T. Finney Fund Lecture will be given by **G. Rainey Williams, MD**, Professor of Surgery and Chairman of the Department of Surgery, University of Oklahoma Medical Center. He was born in Atlanta, Georgia, and received his MD degree from Northwestern University School of Medicine in Chicago. Dr. Williams served an internship, residency, and fellowship at The Johns Hopkins, where he was resident surgeon from 1957 to 1958. He received board accreditation from the American Board of Surgery in 1959 and from the Board of Thoracic Surgery the same year.



Dr. Williams

Dr. Williams was on the V-12 Program of the U.S. Navy from 1944 to 1945, and was on the Medical Service of the U.S. Army from 1953 to 1955. From 1951 to 1958 he was on the teaching staff at The Johns Hopkins University School of Medicine, and since that time has had various teaching appointments at the University of Oklahoma School of Medicine. Dr. Williams has many fraternal affiliations, is a member of numerous professional societies, and is the author of over 50 publications.

The civic activities of Dr. Williams include membership on the Board of Directors of the Village Bank, the Oklahoma City Symphony, and Casady School; Director of the Oklahoma chapters of the American Cancer Society and American Red Cross; and membership on the Health and Hospital Planning Committee of the Community Council of Oklahoma City.

Also on Wednesday afternoon, May 12, **George E. Schreiner, MD**, will give the Albert E. Goldstein Memorial Lecture. Dr. Schreiner is Professor of Medicine at the Georgetown University School of Medicine and Director of the Renal and Electrolyte Division at the Georgetown University Hospital. He was graduated magna cum laude from Canisius College and received his MD degree from the Georgetown University School of Medicine.



Dr. Schreiner


Dr. Schreiner's postgraduate training includes an internship on the medical service at the Boston City Hospital. He was also an assistant in physiology at the New York University School of Medicine, a fellow in medicine at the New York University College of Medicine, a senior resident in medicine at the Veterans Administration Hospital in Washington, and a Captain, MC, USAR, Department of Surgical Physiology, Army Medical Service Graduate School and Korea and Japan Survey Team for Field Medical Research.

The associations of which Dr. Schreiner is a member are too numerous to list, but among them are the District of Columbia Chapter of the Federation of Clinical Research (president), the American Society for Artificial Internal Organs (president), the District of Columbia Medical Society (president), the Third International Congress of Nephrology (secretary-general), and *Nephron and Transactions-Asaio* (editor-in-chief). Dr. Schreiner is author or co-author of over 200 scientific articles and abstracts. He is also the author or coauthor of 17 books.

A pioneer nephrologist, scientist, educator, writer, artist, and innovator, he has an avid interest in geese, which is typical of his concern for all organic life. This interest developed as he watched these geese fly by his country home, 25 minutes from Washington, after the flight had passed on north. They stayed and were tamed to the point where they can be hand-fed.

As a life member of the Friends of the Zoo, Dr. Schreiner is often called in as a consultant on cases involving animals at Washington's National Zoological Park. When he was called in to examine a tiger that became ill, he first treated it for diabetes because of its elevated blood sugar level. However, after further tests it was found that the urine contained protein and fat granules, suggesting kidney disease. The diagnosis of primary kidney disease was made. Dr. Schreiner taught the zoo attendants how to dialyze a tiger and in the months that followed he prepared a series of color slides tracing the tiger's case from diagnosis to death. With the aid of the slides, he has been able to effectively "preach the value of urinary sediment as a screening test" to determine primary kidney disease. Dr. Schreiner discusses kidneys affectionately, and with a deep sense of respect.





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Of The

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### MAY 12, 13, 14, 1971

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**ANNUAL MEETING - ROOM RESERVATIONS, MAY 11 - 13, 1971**  
**MEDICAL AND CHIRURGICAL FACULTY**

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Reservations must be received not later than two weeks prior to opening date of meeting. Rooms will be held **ONLY UNTIL 6:00 PM** on date of arrival, **UNLESS** Hotel is otherwise advised.

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When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

**Contraindications:** Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

**Warning:** Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

**Adverse Reactions:** Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

**Convenience of two dosage forms:** TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-103 / 2/71 / U.S. PATENT NO. 3,001,910



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unwelcome bedfellow for any patient—  
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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

**Prescribing Information — Composition:** Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



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Specific therapy for night leg cramps



The federal government now has the authority to expand the U.S. Public Health Service to provide direct medical and other health-care services in ghettos and rural areas where there are shortages of physicians and other health personnel.

Before such a program can be started, the state and local medical society must certify that it is needed.

The Senate approved the authorizing legislation, 66 to 0, and the House by an almost unanimous voice vote. President Nixon signed it into law on December 31, although the Secretary of Health, Education and Welfare, and the PHS surgeon general had asked Congress to defer action until the President had presented his overall health program early this year.

The legislation authorized \$10 million for the current fiscal year ending June 30, 1971, \$20 million for fiscal 1972, and \$30 million for fiscal 1973. The money must be appropriated before it is available for the program.

In its report approving the legislation, the House Commerce Committee expressed a hope that it would help revitalize the PHS which the Nixon Administration reportedly has been planning to further downgrade, or even eliminate, in a reorganization of HEW's health activities.

"That the Public Health Service has been allowed to languish, and that the great functions it has performed have largely been stripped from it, is the fault of this and previous administrations, and a tragedy from the standpoint of the nation's health needs," the committee report said.

Physicians enlisting in the program will become PHS commissioned officers and, as such, be exempt from the military draft. Fees paid for their services will be set by the HEW secretary and go into the U.S. treasury.



## THE MONTH IN WASHINGTON

The HEW secretary has the responsibility of determining, after consultation with local officials and health groups, what areas need such a program. He then can assign PHS personnel there after receiving a request from a state or local health agency or other public or non-profit private health organization and a certification of need from the state and local medical society.

The new law—the "Emergency Health Personnel Act of 1970"—also provides for the establishment of a 15-member National Advisory Council on Health Manpower Shortages. It will include three members from the health professions, three members from state health or health planning agencies, four members from the general public representing consumers of health care, and five others.

\* \* \*

**Three major reports before the federal government urge extensive programs to combat cancer and heart disease.**

A special panel of 26 expert consultants, in a report to the Senate Labor and Welfare Com-

mittee, urged a multibillion-dollar crusade against cancer in an effort to erase the "staggering" impact of death and suffering caused by the disease.

The National Advisory Cancer Council urged increased educational efforts by both governmental and private agencies to warn the public against the hazards of smoking.

The Inter-Society Commission for Heart Disease Resources recommended a program that would promote drastic changes in the nation's dietary habits, elimination of cigarette smoking, and research into the causes of high blood pressure.

The latter two bodies were set up by the Department of Health, Education and Welfare. The heart disease commission is made up of more than 100 experts in cardiovascular disease, epidemiology, radiology, rehabilitation, and surgery from 29 medical organizations, including the American Medical Association, the American Heart Association, the American Nurses Association, the American Hospital Association, and the College of Cardiology.

Based on a four-month study, the cancer report to the Senate



committee included an estimate that 50 million Americans now living will develop the disease and that 34 million of them will die unless immediate steps are taken to curb it.

The consultants recommended a sweeping program keyed to consolidation of all existing cancer research projects into a national cancer authority directly responsible to the President.

"The Committee is unanimously of the view that the conquest of cancer is a realistic goal if an effective national program along the lines in the report is promptly initiated and relentlessly pursued," said Benno C. Schmidt, co-chairman of the group.

The report recommended doubling cancer research spending to \$400 million in the 1972 fiscal year, and increasing it by \$100 million to \$150 million in subsequent years to a \$1 billion level in 1976.

The panel of consultants, which included labor and civic leaders as well as distinguished cancer researchers, said that the program should be devoted primarily to research into the causes and cures of cancer, rather than to patient care.

The National Advisory Cancer Council's fourth annual report on the state of the art in cancer research cited that more than 60,000 deaths a year in the United States from an "epidemic" of lung cancer attributed mainly to cigarette smoking. The report dealt with the chemical causes of cancer and the effects of many environmental factors, not only the "private pollution" of smoking but also the more public air pollution from industrial and commercial wastes, as causative agents in malignant disease.

As of January 2, 1971 a ban on all cigarette advertising on television and radio became effective under legislation approved in the Congress, and all

packages of cigarettes manufactured and sold in the United States now must carry a new printed warning: "The Surgeon General has determined that cigarette smoking is dangerous to your health." This replaced the milder warning required by a 1965 law that expired in 1969 which said: "Caution: cigarette smoking may be hazardous to your health."

Although a substantial portion of this report of the council was devoted to the problem of smoking and health, it was stated that the production of cancer by chemicals is part of a larger problem of the hazards facing man in a polluted environment. The report pointed out that the death rate from cancer continues to increase despite steady improvement in the cure rate, and suggested that this may be related largely to increased exposure of the population to cancer-causing agents in the environment.

The heart disease commission's report said the nation's cholesterol-rich diet, cigarette smoking, and high blood pressure are the primary reasons for 1 million heart attack deaths and 600,000 heart disease deaths in the United States annually. The report cited five secondary factors: obesity, diabetes, tension, sedentary living, and heredity.

The commission urged "safe and reasonable" changes in everyone's diet to reduce saturated fats and cholesterol even though present evidence that such dietary changes would help is now "suggestive" rather than "conclusive". In an effort to obtain "conclusive" evidence, the commission's experts recommended large-scale, federally-financed scientific studies of American eating habits and their consequences in terms of heart-artery health or illness. The commission envisaged studies costing about \$80 million, requiring ten years and involving

some 60,000 persons on typically high-fat diets as subjects.

\* \* \*

**The Nixon Administration has been urged by a "Health Caucus" headed by the American Medical Association's President to give a high priority to health services for children.**

The caucus comprised representatives of the AMA, the Women's Auxiliary to the AMA, and the American Dental Association at the White House Conference on Children. Walter C. Bornemeier, MD, President of the AMA, was chairman.

Stephen Hess, chairman of the conference, said he would forward to President Nixon a letter outlining the unanimous views of the caucus. The letter was accompanied by a resolution on child health care adopted by the House of Delegates at the AMA's 1970 clinical convention in Boston, Massachusetts. The caucus cited the resolution's five recommendations as examples of steps that should be taken to improve child health care. The health caucus recommends:

—That relevant parent health education related to total health of the mother, leading to the seeking of prenatal care, be made available on a wide scale.

—That medical care that anticipates high-risk mothers be made more readily available.

—That in each state a system of intensive-care units of potential high-risk mothers and infants be developed.

—That the conference urge the expansion of the health aspects of programs for all school children.

—That all payors of health care (the insurance industry) structure their contracts to cover the newborn from the moment of birth.

\* \* \*



**The Baltimore Ostomy Association** recently conducted a special educational program at the library of Pimlico Junior High School.

"People Helping People" was the theme of the evening program. Its prime purpose was to educate physicians, nurses, ostomates, and their families on the free volunteer services the Baltimore Ostomy Association offers the community.

**Marvin Schuster, MD**, Medical Advisor to the club, was the MC.

\* \* \*

**Allen F. Voshell, MD**, medical director and surgeon-in-chief of the James Lawrence Kernan Hospital, recently retired from active service.

Dr. Voshell's career in Maryland medicine has been a long and distinguished one. He was chairman of the Commission for Study of Chronic Illness in Maryland. He was also a consultant to U.S. Public Health Service Hospital. His other current scientific activities include: Maryland Health Department; Baltimore City Health Department and State Board of Education; and the department of physical medicine at the University of Maryland.

He also served as a visiting orthopedic surgeon at a number of Baltimore hospitals.

\* \* \*

**Art H. Panayis, MD**, obstetrician and gynecologist, was recently elected President of the Howard County Medical Society.

\* \* \*

The **Central Association of Obstetricians and Gynecologists** offers annual awards for outstanding investigative or clinical work in the field of obstetrics and gynecology. The annual prize award of \$1,000 and a certificate of merit award of \$500 will be presented to the

## MEDICAL NEWS

two successful authors at the annual meeting, September 23-25, 1971, at the Greenbrier in White Sulphur Springs, West Virginia.

The papers will be presented by the essayists as part of the scientific program and will be offered for publication to the *American Journal of Obstetrics and Gynecology*.

Those eligible to compete are accredited physicians, teachers, research workers, and medical students whose work was done within the geographic area of the association. Original papers written expressly for this competition must be submitted to the secretary in triplicate, not later than May 1, 1971.

For further details contact the Secretary, David G. Decker, MD, 200 First Street, S.W., Rochester, Minnesota 55901.

\* \* \*

The American Academy of Dermatology recently presented awards of merit for outstanding scientific exhibits at the close of its 29th annual meeting.

**Harry M. Robinson, MD**, **Carolyn Pass, MD**, and **Emmanuel H. Silverstein, MD**, all of Baltimore and the University of Maryland School of Medicine, received gold awards for an exhibit on ways to protect the rehabilitation potential of patients with chronic skin diseases. This exhibit was deemed to have the best teaching value.

\* \* \*

**Richard E. Smith, MD**, Hagerstown, has been granted mem-

bership in the American College of Physicians.

\* \* \*

**Robert M. Barnett, MD**, FACOG, of the Department of Obstetrics and Gynecology of South Baltimore General Hospital, recently authored two articles published in the journal of the American College of Obstetricians and Gynecologists, *Obstetrics and Gynecology*. These were: "Modern Kelly Plication" (November 1969), and "Ball Combined Cystopexy" (October 1970).

\* \* \*

**Louis W. Doroshov, MD**, FACS, of Baltimore, has announced the termination of his association with Victor Salama, MD. However, he will continue the practice of urology at 200 W. Cold Spring Lane in Baltimore, and at 325 Hospital Drive in Glen Burnie.

\* \* \*

**Maxwell N. Weisman, MD**, Director of the Maryland State Division of Alcoholism Control, Department of Mental Hygiene, was recently appointed to the National Advisory Committee on Alcoholism.

The National Advisory Committee on Alcoholism was created in 1966 to provide the Department of Health, Education, and Welfare with advice and guidance concerning the DHEW role in reducing the incidence of alcoholism and the other



problems of alcohol use and abuse.

\* \* \*

**Jonathan E. Rhoads, MD**, Philadelphia, is the new president-elect of the American College of Surgeons. He was chosen for the post at the 1970 annual meeting of the fellows in Chicago.

Dr. Rhoads is a graduate of The Johns Hopkins University School of Medicine.

\* \* \*

The **American College of Surgeons** will conduct its joint sectional meeting for surgeons and graduate nurses in New Orleans next month.

**J. Alex Haller, Jr., MD**, Baltimore, will participate both as a speaker and as a moderator at various sessions.

\* \* \*

The following members of the American Society of Anesthesiologists have recently become Fellows of the American College of Anesthesiologists: **Shur-Shing Chu, MD**, Landover; **Jai Sung Lee, MD**, Baltimore; **Ragbhir Singh Mahajan, MD**, Hyattsville; **Roberto N. Navarro, MD**,

Baltimore; **Urmila Patel, MD**, Oxon Hill.

\* \* \*

**Issam F. el-Damalouji, MD**, was recently elected Chief of the Medical Staff of Calvert County Hospital for a two-year term.

\* \* \*

The American Hospital Association's Board of Trustees has named **Edwin L. Crosby, MD**, to the position of Executive President of the organization, which represents more than 7,000 hospitals and health care institutions.

A native of Rochester, New York, Dr. Crosby graduated from Union College, Schenectady, New York, and Albany Medical College. He received his doctor of public health degree from The Johns Hopkins University.

\* \* \*

Fourteen former surgical residents of the James Lawrence Kernan Hospital returned to Baltimore recently to comprise the faculty for the scientific sessions observing the 75th anniversary of the hospital.

Surgical management of heteroptic ossification was described by **George Wahrton, MD**, resident in the department of orthopedic surgery at the University of Maryland Hospital, and **T. Hugh Morgan, MD**, professor of orthopedic surgery at the University of Maryland School of Medicine.

**Robert C. Abrams, MD**, surgeon-in-chief at Kernan and **W. Haddox Sothorn, MD**, resident in orthopedic surgery at the University of Maryland Hospital, presented some of their experiences in the treatment of Legg-Calve-Perthes Syndrome.

\* \* \*

**Sidney Novenstein, MD**, was recently elected president of the Washington County Medical Society. He succeeds **Edward W. Ditto, III, MD**.

\* \* \*

**William Kelly, MD**, spoke on the pathogenesis and therapy of gout at a recent meeting of the Maryland Society for the Rheumatic Diseases.

Dr. Kelly is currently associated with The Johns Hopkins Hospital.

\* \* \*

**Jerome Robinson (center)** associate judge of the Municipal Court of Baltimore city, receives a silver bowl upon being elected an honorary fellow of the Maryland Psychiatric Society. Presenting the award (at left) is **Russell R. Monroe, MD**, president of the society. Looking on is **Perry C. Talkington, MD**, of Dallas, Texas, who has been nominated for the presidency of the American Psychiatric Association. Judge Robinson received the award in recognition of his efforts to improve mental health services in Maryland in the past 30 years.





**Lewis H. Dennis, MD**, Silver Spring, was recently elected to the International Society of Hematology in Munich.

\* \* \*

**R. Gerard Willse, Jr.**, has been elected president of the Board of Trustees of **Church Home and Hospital**.

A trustee at Church Home since 1951, Mr. Willse is a general partner of Alex Brown & Sons and serves on the regional Panel of Arbitrators of the New York Stock Exchange.

\* \* \*

When a shipment of illicit drugs comes into the Washington area, scientists are sometimes the first to find out.

"We can tell because new materials show up in test results," says Howard Willner, who directs the Washington Reference Laboratory. This laboratory, the largest of its kind in the world, examines urine samples to detect illicit drug use among addicts on methadone treatment.

The laboratory's establishment and operation were encouraged by Georgetown University, Providence, and Prince George's General hospitals.

\* \* \*

The University of Maryland at Baltimore has initiated the nation's first interdisciplinary education program in alcoholism, with the aid of a grant from the National Institutes of Health.

William Bosma, appointed July 1 as executive coordinator of alcoholism education for the UM at Baltimore, will plan and direct the integration of alcoholism studies into the curricula of all professional schools—first medicine, nursing, and social work; later dentistry, law and pharmacy. Clinical experience will be emphasized, and eventually the program will concern itself with addiction in general.

\* \* \*

**Zorayda R. Menese, MD**, of Oxon Hill, and **Thomas Juey-Kong Tuong, MD**, of Baltimore, were recently selected as diplomates of the American Board of Anesthesiology.

\* \* \*

For the first time in the 12-year history of the Maryland Academy of Sciences Outstanding Young Scientist Award, two individuals have been selected to share the honor in 1970, according to Robert P. Rich, MD, Academy president.

**Doctors Herbert S. Bennett, of Rockville**, and **Pedro Cuatrecasas, of Baltimore**, will each receive an Allan C. Davis Medal and will divide the \$500 reward.

Six other young Marylanders will be honored as Distinguished Young Scientists. They are: **Doctors Evangelos N. Moudrianakas**, associate professor, Department of Biology, The Johns Hopkins University; **John P. Doering**, associate professor of chemistry, The Johns Hopkins University; **Walter Braun**, research chemist, National Bureau of Standards; **Richard I. Joseph**, associate professor of electrical engineering, The Johns Hopkins University; **Laure Aurelian**, assistant professor of microbiology, The Johns Hopkins University School of Medicine; and **Benjamin M. Zuckerman**, assistant professor of astronomy, University of Maryland.

\* \* \*

The House of Representatives has approved legislation to increase the number of family physicians in the United States.

This legislation authorizes appropriation of \$425 million over a five-year period to support training of family physicians in medical schools and hospital residency programs; training of teachers to teach family medicine; and training of paramedical personnel to assist family

physicians to treat more patients in their practice.

\* \* \*

**Gerald S. Gotterer, MD**, assistant professor of physiological chemistry, has been appointed assistant dean for student affairs at The Johns Hopkins University School of Medicine.

Doctor Gotterer came to Johns Hopkins in 1959 as a fellow in the department of physiological chemistry. He received his doctorate in 1964 from Hopkins and then joined the faculty as an instructor in physiological chemistry. He was promoted to assistant professor in 1966.

\* \* \*

**Congress appropriated for the Department of Health, Education and Welfare more than \$300 million more for the current fiscal year (1971) for its health programs, other than medicare and medicaid, than was requested by the Nixon Administration.**

The appropriation approved by Congress was a compromise between House and Senate figures and represented increases over Administration allotments with the exception of the two for the Food and Drug Administration and Comprehensive Health Planning which were the amounts requested—\$89.5 million and \$247.1 million, respectively.

The total HEW appropriation for specific health programs amounted to \$739.9 million. The National Institutes of Health appropriation included \$275.9 million for health manpower programs, \$33.7 more than asked. The mental health appropriation totaled \$379.5 million, a \$32.8 million increase. A \$196.5 million appropriation for medical facilities construction included a \$107.2 increase. There was a \$300,000 increase in the maternal and child health appropriation of \$255.6 million.

\* \* \*





DOUGLAS G. CARROLL, MD, EDITOR

## rehabilitation notes

# Patterns of Medical Care In A Municipal Hospital

Between July 1, 1968 and December 30, 1968, 305 inpatients from the acute services of the Baltimore City Hospitals were referred to the Department of Physical Medicine and Rehabilitation for evaluation and treatment.

The patients were typical of those seen on acute surgical and medical services of a municipal hospital. Many of them were elderly and had multiple diseases. A smaller number were young people who had acute accidents, fractures, and head injuries.

### Methods

Every patient had a complete diagnostic work-up on the acute wards. These are staffed by residents; the medical students from two medical schools serve as clinical clerks on the wards and there are no private patients. At the time the patient was seen in the Department of Physical Medicine and Rehabilitation, he had generally had an elaborate diagnostic work-up and had been started on definitive therapy. Fewer patients were seen on the wards. The most common diagnoses were neoplasm (39), respiratory disease (33), chronic brain syndrome of various causes (29), right hemiplegia (27), left hemiplegia (27), cardiac failure (12), amputations (10), peripheral neuritis (9), brain stem cerebral accidents (8), skin disease (7), uremia (7), and rheumatoid arthritis (6). There were too few patients with other diagnoses to allow analysis.

Each patient had a mental status check list (MSCL) score<sup>1</sup> performed as well as an activity of daily living (ADL) score.<sup>2</sup> The patient was then seen by the Chief of Physical Medicine and Rehabilitation, examined, and a note dictated as to disposition and treatment. In addition, a prediction was

made concerning whether the patient's condition would improve, remain unchanged, or deteriorate in physical performance as measured by the ADL score.

Of the total 305 patients, 22 patients were thought to be too deteriorated to be able to benefit from treatment in the Department of Physical Medicine and Rehabilitation. All other patients were accepted and had a repeated ADL score at one week when they were seen by the Chief of Physical Medicine and Rehabilitation. ADL scores were performed monthly and at the time the patient was discharged from therapy. The final ADL score was then compared with the initial score and criteria for classifying the patient as *improved*, *unchanged*, or *deteriorated* were applied.<sup>3</sup> Because of the nature of the measuring device, it was impossible for patients who had an initial ADL score of 100 to attain any further improvement in score. On the other hand, patients whose initial ADL score was from 0 to 20 could not, by definition, deteriorate.

### Results

One hundred and sixty-seven patients (55%) had



a correct functional prediction, ending up in the category which had been predicted for them. Twenty-two patients (7%) were not accepted. Nineteen patients (6%) performed better than had been predicted, and 97 patients (32%) performed worse than had been predicted. Results of functional pre-

dictions for certain diagnostic categories are shown in Table I. Table II compares age, sex, initial ADL score, initial MSCL score, and number of diseases in the different groups. Table III shows a breakdown of the ADL and MSCL scores in terms of correctness of prediction as to physical function.

Table I: The most common diagnoses encountered and the correlation of initial prediction of outcome compared to actual outcome

Diagnosis	Total	Correct Functional Prediction	Better Than Predicted	Worse Than Predicted	Not Accepted
Neoplasm	39	19	5	10	5
Chronic Lung Disease	33	22	1	10	0
Chronic Brain Syndrome	29	12	1	9	7
Right Hemiplegia	27	16	4	6	1
Left Hemiplegia	27	8	0	18	1
Cardiac Disease	12	8	0	3	1
Amputations	10	6	0	3	1
Peripheral Neuritis	9	8	0	1	0
Brain Stem Vascular Lesion	8	3	2	2	1
Chronic Skin Disease	7	4	0	3	0
Uremia	7	4	0	2	1
Rheumatoid Arthritis	6	5	0	1	0
<b>TOTAL</b>	<b>214</b>	<b>115</b>	<b>13</b>	<b>68</b>	<b>18</b>

Table II: Initial data and final disposition of patients in different groups (maximal six months after admission)

		Totals	Correct Functional Prediction 167	Better Than Predicted 19	Worse Than Predicted 97	Not Accepted 22
Age			60 ± 16	59 ± 17	60 ± 16	63 ± 22
Male		168	95	7	56	10
Female		137	72	12	41	12
ADL			59 ± 38	40 ± 33	52 ± 28	11 ± 10
MSCL			25 ± 17	22 ± 18	31 ± 8	12 ± 4
Number of Symptomatic Diseases	1.	126	78	7	34	7
	2.	47	25	5	15	2
	3.	131	63	7	48	13
	4.	1	1	0	0	0
Disposition						
1. Died		48	23	2	16	7
2. Discharged		188	113	11	64	0
3. Being Treated in P.T.		28	17	3	6	2
4. In hospital, not being treated		41	15	2	11	13



Table III: Initial ADL and MSCL scores related to functional predictions

	Correct Functional Prediction	Better Than Predicted	Worse Than Predicted	Not Accepted	Total
ADL Score 0	30	6	0	14	50
1 - 20	16	1	9	5	31
21 - 40	14	4	31	2	51
41 - 60	16	5	22	0	43
61 - 80	19	1	14	0	34
81 - 95	22	2	18	0	42
100	50	0	3	1	54
<b>TOTAL</b>	<b>167</b>	<b>19</b>	<b>97</b>	<b>22</b>	<b>305</b>
MSCL Score 0	16	3	3	8	30
1 - 10	9	1	3	3	16
11 - 20	20	3	13	5	41
21 - 30	28	6	13	3	50
31 - 40	22	4	23	0	49
41 - 50	44	2	26	2	74
<b>TOTAL</b>	<b>139</b>	<b>19</b>	<b>81</b>	<b>21</b>	<b>260</b>

### Discussion

It is essential to be able to make some prediction of functional potential of patients being seen in a Department of Physical Medicine and Rehabilitation. This procedure is usually done, but the criteria which are available for judging whether improvement has or has not occurred are so numerous and complex that it is difficult to make any quantitative prediction. The present study attempts to take one important function (the ADL score) and use it as the sole criteria in judging improvement. There are a number of difficulties in using such a scale to measure physical function and also in deciding what will constitute improvement. Despite the difficulties, it appears that using the ADL score is more accurate than clinical impression alone. This score should help to identify which factors seen initially may be expected to be associated with improvement.

The prediction made initially as to whether or not improvement would occur was made taking all factors of the disease, its prognosis, the patient's mental functioning, and his social background into consideration. Thus, this study has been set up in an attempt to evaluate how accurate a clinical prediction is when examined in semiquantitative terms of the ADL score.

Analysis of Table I shows that more than one half of the predictions were correct. One third did not do as well as predicted. Patients with left hemiplegia did strikingly worse than other groups.

Table II shows that women performed better than predicted more often than men. The more diseases the patient had, the more likely he was to do worse than predicted.

Forty-eight patients died within six months, and 113 were discharged.

### Conclusions

Prediction of physical function is accurate in only slightly more than 50% of those patients selected for treatment in this series. These patients were all seen within several weeks of acute hospital admission. Those who were not expected to be helped by any stretch of the imagination were eliminated when first seen. The results show that predictions as to future function were far more optimistic than what actually happened. Relatively few patients performed better than expected. Patients with left hemiplegia performed particularly poorly relative to expectations.

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Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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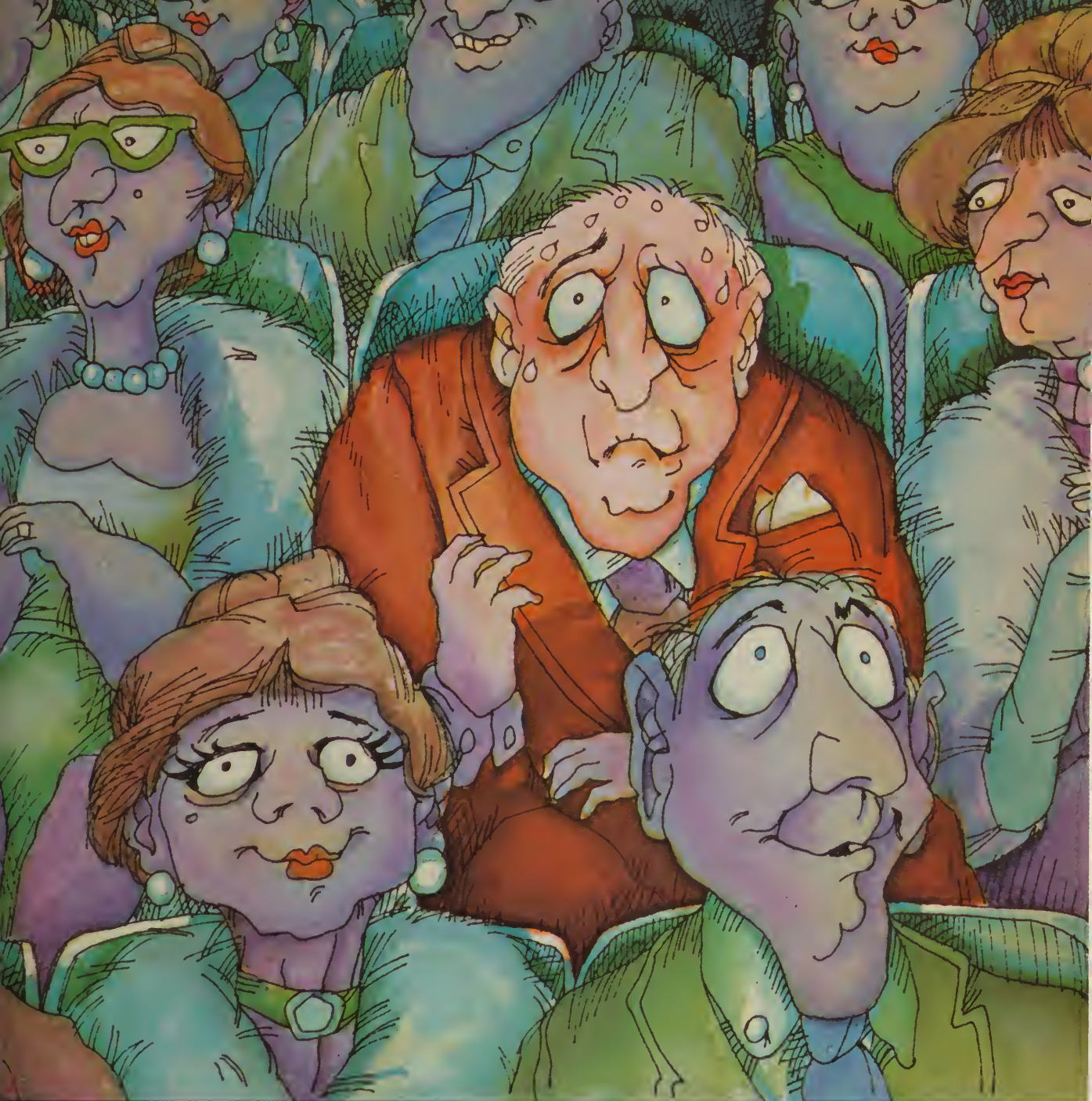
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**Adverse Reactions:** Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant

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 2-5 yr. .... 1 tsp. t.i.d. (6 mg.)  
 5-8 yr. .... 1 tsp. q.i.d. (8 mg.)  
 8-12 yr. .... 1 tsp. 5 times daily (10 mg.)  
 Adults: .... 2 tsp. 5 times daily (20 mg.)  
 or 2 tablets q.i.d.

\*Based on 4 cc. per teaspoonful.

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Maintenance dosage may be as low as one-fourth the initial daily dosage.

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## Book Reviews

**THE CLINICAL RECOGNITION OF CONGENITAL HEART DISEASE**, Joseph K. Perloff, MD; The W. B. Saunders Company, Philadelphia, Pennsylvania 1970.

Dr. Perloff has, for over a decade, held weekly conferences on congenital heart disease at the NIH, Bethesda, Md. This book is a result of the response to these conferences.

An attempt has been made to ensure maximum use of the publication and to this end it encompasses congenital heart disease in all age groups. It is stated that no existing book is devoted to this concept. The point of view employed should prove simple enough to encourage its practical use, yet it is comprehensive enough to interest specialists as well.

It is a book that should occupy the library shelves of all those physicians interested in heart disease.

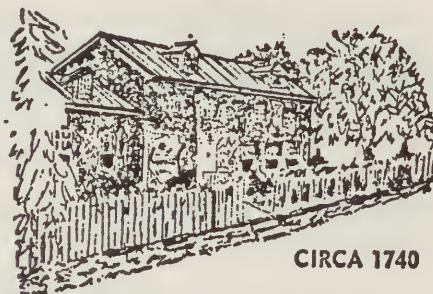
**MEDICAL PHARMACOLOGY—Principles and Concepts**; Andres Goth, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

The fifth edition of this book differs in several ways from previous ones. First of all, several chapters have been thoroughly rewritten. A new appendix on drug interactions has been added, reflecting the growing importance of the subject to medical practitioners. It has also been documented with a long list of current references.

In addition, this new edition has been streamlined by eliminating the material of lesser importance that accumulates in any book that goes through so many editions.

In this day and age of criticism of the drug industry and the profession for use of drugs unnecessarily and without adequate rationale, this book is almost a must for every physician, whatever field of medicine he practices.

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## SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 12, 13, 14, 1971

Baltimore Civic Center

More space is available than in former years. However, it is suggested that applications be submitted as soon as possible.

### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO

NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: \_\_\_\_\_  
\_\_\_\_\_
2. Please attach a 50-100 word description of the exhibit: \_\_\_\_\_  
\_\_\_\_\_
3. Give amount of space required, depth, width, and height: \_\_\_\_\_  
  
If exhibit has side panels, are depth and width included above? \_\_\_\_\_  
  
If not, what additional space is required? \_\_\_\_\_
4. Electrical or other requirements: \_\_\_\_\_  
\_\_\_\_\_
5. Has exhibit been shown at other medical meetings? \_\_\_\_\_  
\_\_\_\_\_
6. Name and title of exhibitor: \_\_\_\_\_  
\_\_\_\_\_
7. Name of institution cooperating in the exhibit: \_\_\_\_\_  
\_\_\_\_\_
8. Address of exhibitor: \_\_\_\_\_  
\_\_\_\_\_

SEE RULES GOVERNING SCIENTIFIC EXHIBITS



THE EXHIBITS—A WORTHY FEATURE  
OF THE EDUCATIONAL PROGRAM  
of the  
MEDICAL AND CHIRURGICAL  
FACULTY ANNUAL MEETING  
at the Baltimore Civic Center  
MAY 12, 13, 14, 1971  
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(as of January 1971)

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Flint Laboratories  
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Lakeside Laboratories, Inc.  
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Marion Laboratories, Inc.  
Maryland Blue Shield, Inc.  
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Symbionics, Incorporated  
Warner-Chilcott Laboratories  
Wills X-ray Supplies, Incorporated  
Wyeth Laboratories  
Hynson, Westcott & Dunning, Inc. is making a contribution, although it is unable to exhibit this year.

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**SEPTEMBER 15-19, 1971**

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

**Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $>5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triam-

terene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

**Supplied:** Bottles of 100 capsules.

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Journal Representative

## Baltimore City Medical Society

# Board of Directors Meets

The first meeting of the new Board of Directors was called to order by the President, Philip F. Wagley, MD, at 4:30 PM. The minutes of the December 1 meeting were approved as distributed and the board then approved such routine matters as waiver of dues for two members of the society who are ill, and the recommendation of emeritus membership for three active members who have recently retired from practice.

In response to solicitation for nominees to receive the Sheen Award, which is given to an American physician in recognition of outstanding contributions to medicine, the board again nominated Helen B. Taussig, MD. This award, given annually since 1968, is a \$10,000 cash prize and a commemorative plaque.

Richard L. London, MD, Treasurer, reported that the Finance Committee recommended that \$10,000 presently being held in a 5% account be converted to a savings certificate drawing higher interest. The committee also reviewed the payment made to the Medical and Chirurgical Faculty for rent and services and recommended that the payment be continued as in the past. Both of these recommendations were approved by the board.

Bernard Karpers, MD, the society's representative to the Task Force on Drug Abuse, presented a report of the activities of that group in the Cherry Hill section of Baltimore. Dr. Karpers stated that the Task Force learned that it could not attack the problem of drug abuse without resolving the underlying problems of lack of comprehensive medical care and socioeconomics in the community. These problems are now being considered by the Task Force and recommendations are forthcoming.

The board had invited Edward J. Hinman, MD, Director of the USPHS Hospital, to the meeting to discuss the possible closing of that facility by the federal government. Dr. Hinman outlined the pri-

mary uses of the hospital along with the negotiations which are being carried on between the hospital and the surrounding community, which greatly needs comprehensive medical-care facilities.

After much discussion, it was agreed to support the resolution presented by the Medical Care Committee at the January 7 general meeting which stated:

"The Baltimore City Medical Society urges the Under Secretary of Health to continue support of the Public Health Service Hospital in Baltimore and to use this important health resource as an integral part of the health service system in our city."

This resolution will be mailed to all members and discussed at the February 4 meeting of the society.

Since there is some urgency in the matter, the board agreed to send the following telegram to the President and the Secretary of Health, Education and Welfare:

"The Board of Directors of the Baltimore City Medical Society has had allegations brought before it that the USPHS Hospital in Baltimore is to be closed. The Board of Directors respectfully wishes to call to the attention of the President and the Secretary of Health, Education and Welfare that the State of Maryland in response to PL 89-749 has enacted a law establishing a regional planning and comprehensive health planning agency. The Baltimore City Medical Society Board of Directors requests that any considerations of closing of the USPHS Hospital in Baltimore be brought before these legally constituted review bodies of the State of Maryland which are charged with the overall planning for the addition or deletion of health care facilities in the State of Maryland."

There being no further business, the meeting was adjourned at 6:15 PM.



## Doctors Take Note . . .

*(Continued from page 6)*

### **MARCH 7-12, 1971**

#### **AMERICAN COLLEGE OF CHEST PHYSICIANS/UNIVERSITY OF MIAMI SCHOOL OF MEDICINE**

Postgraduate Program—Problems and Approaches to the Diagnosis and Management of Cardiopulmonary Failure: Miami Beach, Florida. Contact: American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

### **MARCH 8-10, 1971**

#### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course in Obstetrics and Gynecology: Ann Arbor, Michigan. Contact: University of Michigan Medical Center, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48104.

### **MARCH 8-12, 1971**

#### **AMERICAN COLLEGE OF PHYSICIANS/UNIVERSITY OF TEXAS, M.D. ANDERSON HOSPITAL AND TUMOR INSTITUTE**

Postgraduate Course—Advances in Medical Oncology: Shamrock-Hilton Hotel, S. Main and Holcombe, Houston, Texas. Emphasis will be placed on the medical and psychological aspects of supportive care of the patient under treatment. Case material will further illustrate specific diseases, diagnostic techniques, complications of management, and results of therapy. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

### **MARCH 10, 1971**

#### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Control of Conception: Chicago, Illinois. Contact: BH Box 451, 950 East 59th Street, Chicago, Illinois 60637.

### **MARCH 11-12, 1971**

#### **UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE**

Postgraduate Course—Current Advances in Practical Neurology: University of Maryland, Baltimore, Md. Contact: University of Maryland School of Medicine, 522 West Lombard St., Baltimore, Md. 21201.

### **MARCH 11-13, 1971**

#### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Marriage, the Family, and Human Sexuality: Seattle, Washington. Contact: University of Washington School of Medicine, Health Science Bldg., Continuing Medical Education, Seattle, Washington 98105.

### **MARCH 15-17, 1971**

#### **NEW YORK UNIVERSITY MEDICAL CENTER**

Postgraduate Course—Remedial Techniques for Cognitive and Perceptual Difficulties in Brain-Damaged Persons: New York University Medical Center, New York, New York. A tuition fee of \$150 is payable when submitting application. Write: Joan L. Bardach, PhD, Institute of Rehabilitation Medicine, Room 622, 400 East 34th Street, New York, N. Y. 10016.

*(Continued on page 74)*



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**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia. Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of SerAp-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea; muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

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**MARTIN I. GOLD, MD**

**President**

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As pioneers in respiratory care, we must travel a long distance, fighting many problems, and wrestling with many issues in pulmonary disease. It is very probable that we are now in a transition state, the benefactors of many technical developments, but most of these unproven and many still to come. Nevertheless, progress in respiratory care is occurring and a common framework within which respiratory care improves and grows is developing.

Respiratory failure may be defined as impairment of the function of the respiratory system, such that arterial blood gas pressures depart from normal limits.<sup>1</sup> Some physicians have used specific criteria to define respiratory failure, such as arterial carbon dioxide tensions above 55 mmHg or arterial oxygen tensions below 60 mmHg in a subject breathing air at sea level. It is of interest that deviation from

normal values in the opposite direction towards respiratory alkalosis and hyperoxia with, for example, a  $P_{aCO_2}$  of 25 mmHg or a  $P_{aO_2}$  of 600 mmHg, is not considered "failure." However, these values are clearly a departure from normality.

There are, of course, other limitations to this sort of definition. A patient in severe status asthmaticus may be incapacitated by breathlessness and yet have



relatively undisturbed blood gases. In addition, victims of chronic pulmonary disease exist in "chronic respiratory failure" with abnormal blood gases, but do well in their compensated state. In certain situations their disease may worsen and an acute respiratory failure is superimposed upon their chronic disease. Another confusing aspect related to a definition of respiratory failure is that the sensation of breathlessness may be completely dissociated from blood gas abnormalities.

In the past ten to fifteen years, there has been an improvement in treating respiratory failure. This may be related to the development of the mechanical ventilator, to the introduction of blood gas electrodes, and to other pertinent technical and scientific advances.

The movement towards improving respiratory care moves relentlessly on. Like the wagon train westward bound, this movement has its scout (the pulmonary physiologist) and its rifleman (the clinical researcher), but the main body, the practicing physician, his nurse, and the therapist remains behind seeking definitive information before committing its wagons to this mountain pass ("the intermittent sigh") or that canyon ("positive end expiratory pressure"). There is always the threat of lack of food and water (anoxia), and the ever-threatening, lurking Indians (hypercarbia). Is there a Little Big Horn—pneumonia, atelectasis, and pneumothorax? And what may this movement consider the United States Cavalry—the mechanical ventilator, the respiratory care unit or blood gas electrodes? It is thought-provoking to consider what concepts and instrumentation will be available a few years hence; certainly the pioneers could have used automobiles, airplanes, and modern weaponry to advantage. But somehow this seems unnatural and strange, for we have come to accept the Wild West as it was, and without Cowboys and Indians as Bret Harte described them, we seem to have lost our heritage.

As pioneers in respiratory care, this analogy actually helps those involved very little, for they have no choice. They still must travel a long distance, fight many problems and wrestle with many issues in pulmonary disease. It is very probable that we are now in a transition state, the benefactors of many technical developments, but most unproven and many still to come.

Today, the mechanical ventilator has become the symbol of progress in respiratory care. It seems natural now for patients who are in respiratory failure to be automatically respired, but it was not always so. In many places throughout the world today and in this country, such patients still struggle to breathe spontaneously. It has come to be accepted in most economically advanced areas that under the correct conditions, the mechanical ventilator is far more advantageous than disadvantageous. However,

we have come to recognize certain disadvantages and complications involved with the clinical use of positive-pressure breathing. In this connection, one should ask the following rhetorical questions:

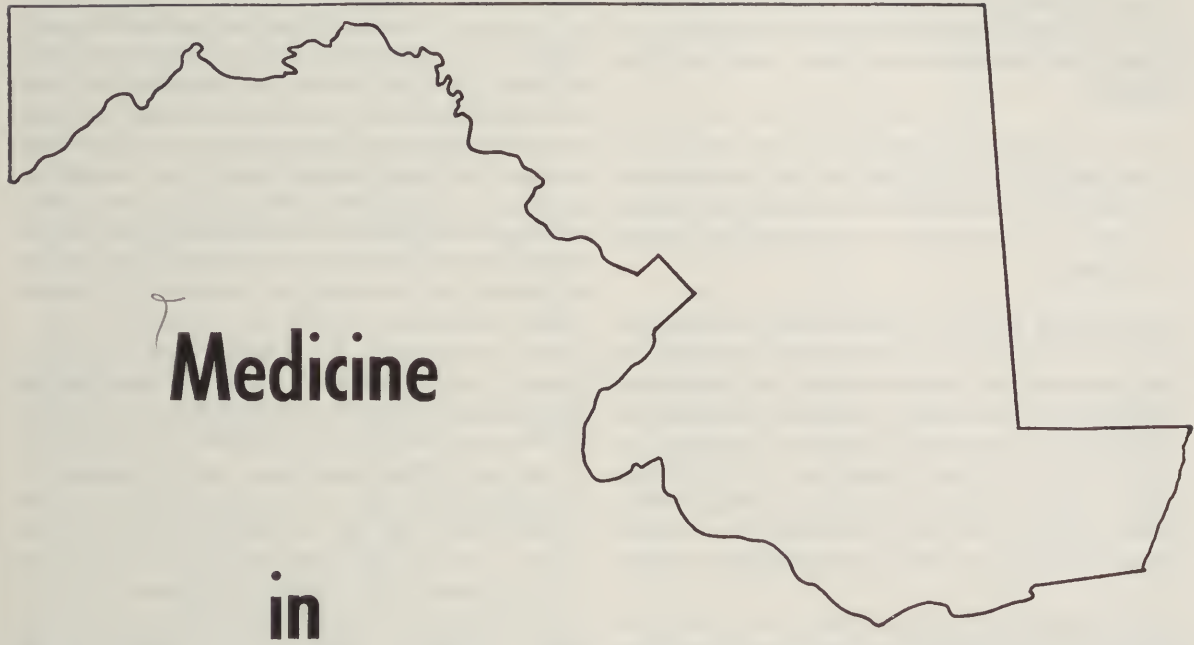
1. Why can we not improve upon the machine-patient interface, ie, the tracheostomy or the endotracheal tube? The material which the prosthetic device is made of, the cuff surrounding the tube, the suctioning procedure, and the connection to the ventilator are only a few pertinent problems which remain unsettled in this area.
2. Why are ventilators so complicated and why does such a variety exist both in this country and overseas, ranging from the terrestrial Beaver to the high flying Bird? There are 60 primary machines and 28 subtypes described in Mushin and Rendell-Baker's second edition of *Automatic Ventilation of the Lungs*, and all are eponyms.<sup>2</sup> Why can they not be standardized and rigid criteria for introduction of new devices imposed? This would be much as in the fashion of new drugs governed by FDA rules and standardization description, as in the *United States Pharmacopia*.
3. How can one justify the purchase of one ventilator for \$6,400, while ten less majestic and versatile units may be purchased for the same price? Both types of ventilators are equally effective, provided the individual using the ventilator is knowledgeable.
4. Why is it so difficult to successfully explain the use of ventilators to house officers, nurses, and students when, in the final analysis, it is so simple? How may inhalation therapists and nurses, who are so sophisticated with respect to respiratory care, function among physicians less knowledgeable but who must provide orders in the area of acute respiratory disease?
5. Why are there so few pediatric and premature infant ventilators when this is a clinical area so much in need of such lifesaving devices?

The answers to these questions are not easily come by. It is possible in the next few years that many problems will be solved through research and clinical trial and error. Nevertheless, progress in respiratory care is occurring, and a common framework within which respiratory care improves and grows is developing. Peter Latham once said, "Next to knowing the truth itself is to know the direction in which it lies. And this is the peculiar praise of a sound conjecture."

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In a study of the medical history of Maryland, three important philosophical attitudes can be identified, emerging at different historical periods. An understanding of these ideas<sup>1</sup> will illuminate contemporary medical practice and hopefully will be helpful in molding the future. These ideas may be epitomized in the lives of individual physicians, in the establishment of certain medical organizations, and in the development of a new methodology. Far from being mutually exclusive, each new idea could be built only on the foundation of the previous idea. Furthermore, each of these ideas is incorporated more or less into present day medical thought. Each philosophical attitude (consciousness) developed in a particular era of history (period).

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The first of these periods (Period I, 1634 to 1799) evolved from the Renaissance and the Enlightenment. At this time there was: breaking away from the intellectual tyranny of the old medical authorities; inductive reasoning replacing deductive; observation replacing extracts of past authorities in medical literature; and experimentation being used to solve problems.

"... the Renaissance started a movement which was looking at the future and the creative and new in it. Hope conquered the feeling of tragedy, and belief in progress the resignation to circular repetition."<sup>2</sup>

The conflict between inductive and deductive reasoning is exemplified in the conflict between the European-educated physicians and the locally-educated (often self-educated) empirics. The former were familiar with the Latin texts of antiquity, as well as the more recent authorities such as Boerhaave, Pringle, and the Edinburgh school. They looked on their professional responsibility as one of writing footnotes to the medical doctrines of the past.

The empirics, on the other hand, saw their purpose as meeting the medical needs of their community. They depended largely on what they saw, generally were not familiar with Latin or the old texts, and learned by trial and error.

Perhaps Richard Brooke (1716-1783), the "first scientific observer in Maryland"<sup>3</sup> was the first physician to exemplify this new attitude in Maryland. He was a naturalist, surgeon, and colonial rebel. His writings contain little reference to past authorities. They contain personal observations, case reports, and incorporate the experimental attitude.

Another mere thread in the early colonial period is government involvement in medical practice. It started with regulation of surgeon's fees in *An Act for Rating Artificers Wages* in 1640. Government regulation gradually increases during this period. Finally, private medical charitable organizations emerge, an important influence running throughout the history of medicine and starting in Period I.

"The evolution of the Protestant ethic into the philanthropic foundation endowed by millionaires is one of the most astonishing transformations of European ideas into American techniques to be found in history."<sup>4</sup>

Starting late in Period I, charitable organizations were founded, informed by religious convictions. As time passed, they became part of the American way of life. Many of their original functions were taken over by local and central government. (Now they have become less service-oriented, attempting to ful-

fill needs not met by government, often in the lay education and research sectors.)

## Period II

Period II (1800-1827) had its roots in Period I, and is epitomized by the 1799 founding of the Medical and Chirurgical Faculty of Maryland. A group of experts was now legally recognized. Licenses were needed to enter the practice of medicine while a school had to be founded to educate the potential initiates. A body of traditions, initiation rites, public and legal recognition of competence, plus a Latin jargon (often intended more to impress than to enlighten) and an oath of allegiance to an out-moded Greek god came to be accepted.

The founding of the Medical and Chirurgical Faculty was a giant step forward in improving the practice of medicine. Its impetus came from a group of concerned physicians scandalized at the quackery of the day. These physicians were determined to bring the best of modern European medical thought to Maryland. We see this same spirit of reform present at about the same time in the beginning of the Baltimore City Health Department in 1793, by the founding of specialty clinics (Dr. James Smith's Smallpox Vaccination Clinics in 1802<sup>5</sup>); the Baltimore General Dispensary in 1800; the first Maryland medical journal (*Medical and Physical Recorder*, 1808); the first hospital (Baltimore Public City or Maryland Hospital started in 1798); and what was to become the University of Maryland School of Medicine in 1807.

During this period, these new organizations struggled to survive, some falling by the wayside, but the survivors were well established by the end of this period (1827).

This period saw the emergence of expertise, both individual (physician specialists) and organizational (hospitals, health departments, medical schools and medical societies). The expertness was often publicly acknowledged by license or diploma. In return for the public recognition of expertness, there was an unstated agreement that the licensed person or institution would be completely responsible for medical care, hospitalization, health, or medical education. It is only in the last decade that each of these groups has had to acknowledge, publicly or privately, that it has not been able to fulfill all of its obligations.

## Period III

The revolutionary idea of Period III (1829 to present) is the scientific method. Clearly it is related to elements of Periods I and II. Just as clearly, it emerged in its modern form only with the developments of new methods, particularly the taking of the medical history, the perfection of the physical exami-



nation, the use of the clinical-pathological correlation, and the use of statistics to analyze the observations.

Tobias Watkins (1780-1855) included statistical information and some post-mortem examinations in his *Medical and Physical Recorder* (1808). And while William Powers (1813-1852) was a pupil of Pierre Charles Alexandre Louis at Paris from 1835 to 1840 and brought back to Baltimore the scientific method in its most sophisticated form in 1840, Thomas H. Wright must be given credit for first applying the new scientific methods in an organized manner in Maryland. We know little about the life of Wright. His date of birth is unknown as is his early history. He received an honorary MD degree from the University of Maryland in 1819 and was appointed to the chair of anatomy at the medical school in 1831. He resigned this post within several months to be replaced by Robley Dunglison, MD. Dunglison explains Wright's resignation as follows:

"Dr. Wright was an exceedingly nervous man, and his apprehensions and sensitiveness became ultimately so great, that he resigned the office before the commencement of the session."<sup>6</sup>

Between 1828 and 1833, Wright contributed 14 long reports on patients from the Baltimore Almshouse Infirmary. The reports consist of three to five similar cases, with history, physical examination and autopsy, followed by a discussion of common features and a clinical-pathological correlation. Together, these reports constitute a textbook of medicine. The fact that the reports begin with the second volume (1828) of the new *American Journal of the Medical Sciences* makes this date a convenient one to designate the beginning of Period III, the era of the scientific method in medicine.

This period builds on the belief in progress and inductive reasoning of Period I. It also continues the specialization and expertise of Period II and adds new techniques: medical history; physical examination; clinical-pathological correlation; statistical analysis; later laboratory procedures; and the development of surgery and powerful drugs. But these advances have been made at a price. The scientific method constituted a turning away from the Platonic thymos (the spirited courageous element in man's makeup), to the intellectual, technical approach. The result was a loss of understanding of the patient as a person.<sup>2</sup>

#### Sources for a Medical History of Maryland

**Primary Sources:** The Maryland Historical Society owns a number of case books of early Maryland physicians, having to do with fees, accounts, and incomes. The best and practically only source for the earliest period may be found in the Archives of Maryland. This source and the newspapers have

been only partially mined for information. Letters to and from early physicians are rare but extremely valuable. Alexander Hamilton's diary of a trip from Annapolis to New England is extremely important as are his letters to his brother in Scotland.

The Medical and Chirurgical Faculty of Maryland also has valuable manuscripts, including some Wiesenthal correspondence and the minutes of the Harford County Medical Society.

Diaries of John Crawford (1746-1813) and Horatio Gates Jameson (1778-1855) have been partially published, but contain little about their experiences in Maryland.

Newspaper sources are quite helpful since, in the absence of professional journals, physicians often published professional articles in the newspapers. The Toner Collection in the Congressional library (manuscripts division) contains a two-volume guide to medical articles in early colonial newspapers.

The professional publications which did appear in medical or scientific journals, in theses and pamphlets, are also of great value. They are particularly helpful in revealing the state of medical theory, diagnosis, and treatment. The Crawford Library at the University of Maryland, the Welch Library, the Library of the Medical and Chirurgical Faculty of Maryland, and the National Medical Library possess most of the early published medical writings of Maryland.

**Secondary Sources:** Of the general histories of Maryland, Sharf's *History of Maryland* (1879, recently reprinted) stands above all others. There is a minimum of interpretation and a maximum of quotation from original sources. Except to the dedicated student of Maryland history, it will be found ponderous, boring, and endless. Matthew Page Andrews' *History of Maryland* (1929) is our only history by a professional academically trained historian.

A series of articles on Maryland medical history were published in the *Maryland Medical Journal* in 1883 by John Quinan.

The introductions to the individual volumes of the *Archives of Maryland* also give an excellent history of Maryland and are closely oriented to the original material of the volume in which they appear. These publications give the political, social, and economic background of Maryland in which medical practice can be understood.

There are two outstanding Maryland medical historians, John R. Quinan (1822-1890) and Eugene Fauntleroy Cordell (1843-1913). Both were infinitely careful in tracing details, following obscure leads, and recounting their findings. Their works are the source books for all present day efforts to investigate Maryland's early medical history. Indeed, it is hard to find an original source which they have not already mined.

John Russell Quinan's *Medical Annals of Balti-*



more (1884) is based on newspaper accounts, the records of the Medical and Chirurgical Faculty and personal knowledge of the medical scene.

Eugene Fauntleroy Cordell wrote *Medical Annals of Maryland, The Centennial Volume of the Medical and Chirurgical Faculty of Maryland* (1903) and *Historical Sketch of the University of Maryland* (1891).

Together, these histories present nearly all the available information on these two important medical organizations.

William Travis Howard (1867-1953) published *Public Health Administration and the Natural History of Disease in Baltimore—1797-1920* in 1924. This is an important collection of disease statistics of Baltimore, and a thoughtful review of social and political aspects of epidemics and public health in Baltimore.

Huntington Williams, MD, former Commissioner of Health for Baltimore, has collected and published *The First Thirty-five Annual Reports of the Baltimore City Health Department* (1953). He has also published historical essays in the *Baltimore Health News* from time to time.

A number of other authors have published medical articles. Louis Henry Steiner (1827-1892), and Hall Pleasants (1873-1957) have written articles on the early medical history of Maryland in the *Johns Hopkins Hospital Bulletin*.

Short histories of medicine in Maryland drawn from secondary sources have been published by Thomas Cullen and Thomas Parran.<sup>7,8</sup>

More recent historians include Alan Chesney's *The Johns Hopkins Hospital and the Johns Hopkins School of Medicine*, George H. Callcott's *History of the University of Maryland* (1966), Harold Abraham's *Extant Medical Schools of Baltimore, Maryland* (1969)<sup>9</sup> and Margaret Ballard's *A University is Born* (1965).<sup>10</sup>

### Interpretation of Historical Documents

Radical historical scholars tell us that history is irrelevant to the solution of problems of the future,<sup>11</sup> but this view is nonsense. Whether we want to or not, we are forced to make important decisions, and the quality of our decisions will be based on our understanding and experience of the past.

The central problem both for historians and private individuals is how to extract from the past the material most applicable to the future. The most successful historian is the one who can make the best predictions. He has to make such predictions on interpretation of the incomplete data of the past and present.

A number of important influences determine the availability of the documentary evidence which form the data of history. Henry Adams hoped for a "scientific history" based on the documents of the

time as the primary data of history.<sup>12</sup> There is a selective process in the survival of original papers. Ephemeral published documents may survive where valuable manuscript materials are thrown on the ash heap. Thus, the early history of medicine in Maryland and Virginia is drawn largely from court and other public records.<sup>13,14</sup> The information available comes largely from coroners' reports, suits for medical fees, and criminal actions. One can glean only a one-sided picture of the physician from such documents. Adams' ideal of the historian as discoverer and arranger of the documents as a "scientific" and objective discipline was a short-lived late flowering of Baconian philosophy.

There is a more radical question in regard to the use of documents as the basic data of history. How representative of a culture is a specific document or particular happening?

"This mode of 'understanding' the particular by seeing it as a document of an underlying whole is rooted in German romantic and conservative thought—a style that was elaborated in great detail and with surprising subtlety and fruitfulness by Wilhelm Dilthey."<sup>15</sup>

Buildings, dances, habits, and attitudes are other potentially basic data for history, but often not available. A document is certainly a manifestation of a certain era, but how representative? Interpretation, in the light of all possible information, must inform the use of basic documents.

James Harvey Robinson<sup>16</sup> emphasized the selective activity of the historian himself. The making of history is a far more complex activity than the "scientific" historian realized. The historian selects his material and arranges it as he thinks fit. He may well arrange the documents to support a theory rather than vice versa.

Max Weber was particularly concerned with the objectivity of interpretation of historical and sociological data. Interpretations change depending on the culture one lives in. "The points of departure of the cultural sciences remain changeable throughout the limitless future."<sup>17</sup> Science is an ongoing process, whose very purpose is to antiquate contemporary interpretations and lead to more adequate configurations. Having suggested that the "data" of history is highly and subjectively selected from a large number of other significant activities and documents, and that interpretation of such "data" goes on at a number of subjective levels, strongly influenced by temperament, contemporary social, economic, and ethical interpretations, we return to the original question for the historian, amateur or professional: How can I use the past to make decisions about the future? This will require recognition today of scientific, emotional, economic, political, and social trends which are harbingers of the future. If we can identify and recognize these trends, we then



have the option of supporting or opposing them.

Kuhn<sup>1</sup> has analyzed in detail the development of scientific ideas in the field of physics over the last several centuries, attempting to identify the revolutionary scientific ideas (paradigms) which emerged. Such paradigms have certain characteristics, recognizable in retrospect. Paradigms emerge after a period when a number of observers have become dissatisfied with the old "normal science". The new idea must be better than its competitors, but it is never completely satisfactory. It tends to solve acute problems. The paradigm stimulates new attitudes, and new alignments. Then it is finally accepted and becomes "normal science". It attracts the young scientists and a new type of scientist emerges who can fulfill the new role. Those who insist on clinging to the older tradition are ignored. Most paradigms of the physical sciences have been greeted with skepticism, angry rejection, and unreasonable personal attack.

"Normal science" on the other hand is the process of developing and exploiting paradigms in a socially acceptable way. In the final analysis, society demands some practical end to its scientific research. It supports practitioners as well as scientists. "Normal science" can demonstrate its importance to society. It often consists of tidying up operations with gradual completion of details.

There are a number of problems with Kuhn's approach to the development of scientific knowledge. It is retrospective. Certain ideas that eventually proved to be important are picked as examples of paradigms. This can be done now because we know what happened. People living at the time of a new paradigm were confronted by a number of other

potential paradigms which did not happen to succeed. Many of these undoubtedly had the characteristics that Kuhn finds typical of paradigms (with the exception that they did not survive).

Kuhn illustrates paradigms from the history of physical sciences. The same ideas can be applied to other components of history.<sup>18</sup> We have suggested that there are philosophical ideas (consciousness 1, 2, and 3) which help in understanding medical history. Initially they were paradigms in Kuhn's sense; once accepted, they become "normal science". The application of Kuhn's ideas to medical history suffers because the paradigms of medical history are less specific, more difficult to identify in time, and far more complex than the paradigms of physical science. Cornfield<sup>19</sup> has made a distinction between sciences which have low and those which have high "articulation". In a science with high "articulation", a few fundamental principles explain a great deal of the science, as in physics. A science with a low "articulation" has few or no underlying principles. Cornfield gives geography as an example. "We must remember that, especially in biology, experimental results are, strictly speaking, only valid for the precise conditions under which the experiments are conducted. Some caution is necessary in drawing conclusions as to how widely applicable are results obtained under necessarily limited sets of circumstances".<sup>20</sup>

Thus, paradigms are less characteristic of the biological and social sciences than of physical sciences.

It is with these reservations that we have divided Maryland medical history into three periods, each with its characteristic (but not necessarily exclusive) philosophical presuppositions.

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Theodore R. McKeldin, Maryland's former governor, has referred to the state as "America In Miniature". This description is quite apt, since its geography, together with its population composition, characteristics, and distribution are a microcosm of the total United States. Many health problems facing Maryland in the coming decade are compounded by the increasing concentration in inner-core metropolitan centers of the community dependent—the sick, the old, and the socioeconomically deprived; migration of white, middle-class residents to suburbs beyond the city limits; and unequal distribution and use of health-related resources and services. These health problems also show Maryland as "America In Miniature". We will present and analyze statistics related to the state's health problems and consider some of the issues facing Maryland in the years ahead. While numbers and place names may differ, these problems and issues are comparable to those existing in many other states. As such, implications of the facts considered here transcend Maryland's boundaries.

# Maryland Faces the 1970's

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The Center for Health Statistics of the Maryland Department of Health and Mental Hygiene is responsible for the collection, tabulation, and analysis of birth and death information and for the preparation of estimates and forecasts of the number of inhabitants in Maryland's major subdivisions by age and race. The following analysis is based in part on these data. Since the state's nonwhite population is more than 98% Negro, the two terms are used interchangeably.

## Analysis of Data

Maryland's population, which passed the three million mark in 1959, is expected to reach four million around December 19, 1971. The number of state residents has increased at an annual rate of 2.3%

since the 1960 census. Although the declining birth rate has been partly responsible for slowing this to the current rate of 1.8% each year, this rise is still somewhat above the national level and reflects continuing substantial net immigration. While we anticipate a continuing expansion in the number of residents, we believe that the rate of increase will gradually decrease. If present trends continue, the state's population should reach five million by 1985.

Population growth has been primarily in suburban areas surrounding Baltimore and Washington. The number of residents in Montgomery and Prince George's counties rose 68.7%, from 698,323 in 1960 to 1,178,344 in 1970. The population of the five Baltimore metropolitan area counties increased by 33% in the same time period (from 864,721 to



1,149,978). The population growth of 765,278 in these two areas compares with Baltimore city's loss of 43,802 residents and a net increase of 52,477 for the rest of the state. Between April 1, 1970 and July 1, 1973, we estimate a further increase of more than 200,000 in the seven suburban counties, a slight loss in Baltimore city, and a gain of about 15,000 in the 16 counties encompassing the rest of the state.

Maryland's white population is rapidly becoming concentrated in the suburban areas; an estimated two thirds now live in these seven counties. This largely reflects the mass exodus of younger, middle-income inhabitants from Washington and Baltimore. The latter area experienced a net outmigration exceeding 100,000 between 1960 and 1970. We estimate that one third of its white population moved to the surrounding counties during the decade. As a result of this migration, the proportion of Maryland's white residents living in Baltimore city declined by more than one third (from 23.7% to 15.2%).

While a majority of Negroes continue to live in the city, this percentage is gradually declining also because of the rapid increase in the number of non-white residents in Washington's suburbs. In 1960, one out of 12 Maryland Negroes lived in Prince George's and Montgomery counties, as compared with one out of seven in 1970. In Prince George's County alone, the number of nonwhite residents reached 80,000 in 1970 as compared with 32,681 in 1960. This probably reflects the relatively large number of middle-class Negroes in this area, many of whom are employed by federal agencies.

Proportionally, the increase in the number of white and nonwhite inhabitants has been virtually identical. Maryland's annual vital statistics reports have consistently shown nonwhite birth rates approximately one third higher than comparable white statistics. This has been nearly balanced by much lower white death rates and by large-scale immigration of white residents from the District of Columbia. The 1960 census reported that 83% of Maryland's population was white; this is expected to be 82.1% in 1970.

However, the racial composition of individual geographic areas has changed appreciably. Baltimore city and Washington's two suburban counties have an increasing proportion of nonwhite residents. The percentage of Negroes in the 16 nonmetropolitan counties comprising the Eastern Shore, Southern Maryland, and Western Maryland has either remained constant or changed only slightly. The five counties surrounding Baltimore all have had small, indigenous Negro settlements, in some cases predating the Civil War. Since almost all people moving into this area in recent years have been white, the Negro proportion of the population has gone down. Some traditional Negro areas outside the city have actually disappeared or decreased in population as

the result of displacement, inability to obtain substitute housing, and migration to Baltimore city. About 46% of Baltimore's current population is Negro, compared with 7% in the surrounding counties. Should present trends continue, the Baltimore metropolitan area will have a polarization of its population within a few years with a black (and largely lower class) majority in the city surrounded by a wide middle-class suburban belt having virtually only white inhabitants.

### Population Changes

Approximately 56% of Maryland's population increase since 1960 resulted from an excess of live births over deaths with the remaining 44% due to net immigration. The rise in the number of residents, which averaged nearly 90,000 a year in the early 1960's, has now slowed to 65,000. Net immigration, which reached an annual maximum of 40,000 in the middle of the decade, is now estimated to be 30,000. The decrease in the number of live births and a gradual rise in the number of deaths has reduced the state's natural increase from 50,000 to 35,000 a year. We anticipate that the population increase will remain near present levels for several years with the rate of growth declining slightly.

Migration has drastically changed the age distribution of residents in the various geographic areas. Proportionally, the concentration of people in the older age groups (65 and over) is now highest in Baltimore and lowest in the suburban counties. Although the city continues to lose population to surrounding areas, we estimate that the number of its aged inhabitants is steadily increasing. In fact, it rose 500 last year. While 9% were in this category in 1960, this is estimated to have reached 10.7% in 1970. Comparable percentages are 5.4% and 5.5% for the seven suburban counties and 9.6% and 9.3% for the rest of the state. In 1960, 57.4% of Baltimore's population was between the ages of 18 and 64, as compared with 55.9% in the suburban counties and 54.3% in the rest of the state. Our estimates for 1970 are 53.9%, 56.2%, and 55.3%, respectively. The percentage of those under 18 in 1960 was 33.6%, 38.7%, and 36.1% as compared with an estimated 35.4%, 38.3%, and 35.4% in 1970.

These figures indicate that, as in other metropolitan centers, a rising proportion of Baltimore city's population is in age groups where most are non-productive and dependent. For every 100 residents between the ages of 18 and 64, there are now 19.8 residents who are older, a figure twice as high as in the suburban counties. The net effect has been a widening age divergence between Baltimore and other state areas with the city increasingly inhabited by the extremes of young and old.



## Birth Rates

As in the rest of the United States, the number of live births to Maryland mothers, both white and nonwhite, has decreased steadily in recent years and is now near the lowest level of the past decade. Despite a slight increase in 1969, the number of live births remains considerably below the levels of recent years. Active and extensive family planning programs have existed for some time in Baltimore and many of the counties and now encompass the entire state. The availability of "the pill" and various birth control devices to all population segments has certainly played a key role in this decline. Another probable factor is the desire for smaller families, and the ability to attain this objective, as reflected by a 47.4% drop between 1960 and 1969 in the number of births of fourth or higher order (from 24,000 to 12,615). The propounded assumption that this decrease in part reflects postponed rather than prevented births appears to be without merit in our opinion. The birth rate, which relates number of live births to size of population, has decreased more than one fourth since 1960, from 24.8 to 18.1 for every thousand. A somewhat more sophisticated measurement is the fertility rate, since its denominator is limited to the number of women in the child-bearing ages (between 15 and 44). This ratio has declined an average of about 3% a year, from 117.8 for every 1,000 in 1960, to a currently estimated 85.7.

A liberalized abortion law, enacted in Maryland in 1968, broadened the legally acceptable indications for this procedure. A total of 2,134 hospital-performed abortions were reported in the next year (the period ending June 30, 1969), a figure considerably higher than that noted in earlier years. A further substantial increase to 5,533 occurred in the year ending June 30, 1970. Although abortions were performed in 27 of Maryland's 39 general hospitals, five of these accounted for 68.3% of all abortions. Most were to Maryland residents and were reported to be performed for the patient's mental health, an indication permissible since 1968.

Our current ratio of one legal abortion for every 12 live births is greatly exceeded by all foreign countries where this procedure is legally permissible and readily attainable. In part, this may reflect the greater reliance here on "the pill" and other means of birth control. In part, also, this difference may reflect the number of illegally performed abortions which here are commonly believed to exceed the number legally carried out. It is, therefore, not possible to determine whether the increase in the last two years in hospital-performed abortions reflected a shift from other previously employed resources or represented a true rise.

A bill adopted by the legislature in 1970 but vetoed

by Governor Mandel would have removed most legal restrictions on abortions. Although the bill's sponsor will not be in the legislature next year, a comparable bill meeting the Governor's stated objectives will probably be introduced in the 1971 session. The extent to which presently prevailing limitations reduce the number of legal abortions and increase the number otherwise performed can, therefore, not be determined. However, our data does indicate that in Maryland, hospital-performed abortions presently have only a negligible impact on the number of live births.

## Mortality Rates

Maryland began the decade of the 1960's with nonwhite age-specific death rates considerably higher than comparable white figures. It probably finished the decade similarly since progress has been minimal, except during the first year of life, for both groups in the succeeding eight years. Although the number of deaths from some causes has declined, this has been balanced by increases in others. For example, tuberculosis deaths decreased from 254 in 1960 to 172 in 1968. Concurrently, lung cancer mortality increased from 670 to 1,144. When adjusted for age variations in the two cohorts, total nonwhite mortality rates are consistently about 60% higher than white mortality rates. Rates differed most in the middle years of life (between ages 18 and 44) and least in the oldest age group (age 65 and over). Had age-specific nonwhite death rates been at the white population levels, there would have been 4,076 deaths in 1968, instead of the 6,494 that actually occurred. This would have reduced the state's total death rate by 7%. This difference of 2,418 reflects 250 excess deaths under one year of age, 106 between 1 and 17, 671 between 18 and 44, 991 between 45 and 64, and 400 in the age group 65 and over. About 2.8% of nonwhite Americans are Maryland residents. Therefore, if the differences in age-specific death rates noted here hold true for the nation as a whole, this would indicate an annual excess nonwhite mortality of approximately 85,000.

As in the total population, heart disease, cancer, vascular lesions, and accidents were the leading causes of nonwhite deaths, in that order, in 1968.

The actual number of Negro deaths at virtually every age by major cause group exceeded the number obtained by applying comparable white rates to the nonwhite population. While excess mortality was relatively small in such categories as heart disease and cancer, it was large in many others. For example, the 224 nonwhite deaths due to homicide would have been 28 on the basis of age-adjusted white rates from this cause; the 145 deaths from infectious diseases would have been reduced to 35; there would have been 136 deaths from influenza and pneumonia instead of the 302 which actually occurred.



## Discussion

Maryland, along with the rest of the United States, begins the new decade with many major, complex, and unresolved health-related problems. Some either are of recent origin or have just begun to receive national attention. Rapid population growth and rising affluence in some state areas, together with increasing industrialization, have led to growing waste disposal and resultant pollution of our air, land, and waterways. Maryland, like most other states, has almost no longitudinal or even current data relating to this issue. However, recognition that the great Chesapeake Bay, the source of employment and recreation for many Marylanders and residents of adjacent areas, is rapidly becoming polluted has undoubtedly been a factor in recent proposals and steps for remedial action. Recommended procedures, if carried out, will be costly and time consuming and conditions therefore may quite conceivably get worse before they get better.

Other health problems are more chronic and either have remained unchanged or actually have worsened during the past decade. The chief problems are those interrelated issues of unequal availability and usage of, and need for, health resources. One result of this—excess nonwhite mortality—can be measured and has been documented here. The problem has undoubtedly become more serious in recent years because of the increasing concentration of the state's community dependent population in Baltimore's inner-core concomitant with the removal from this area of many health services. Although Baltimore now has less than one quarter of all state residents, its population includes a majority of Maryland welfare recipients, admissions to state-operated mental and tuberculosis hospitals, and applicants for Medicaid services. The gap in per capita income between city and suburban county residents is widening appreciably. At the same time, five (Franklin Square, Greater Baltimore, St. Joseph, Sinai, and South Baltimore) of the ten major hospitals which were in the center of the city have been relocated to outlying areas. Three are now in Baltimore County. Generally, this has resulted in the closing of outpatient as well as inpatient units. The remaining hospitals are encountering growing problems in serving their catchment areas. Also, Baltimore newspapers have recently reported that general medical practitioners in private practice are virtually nonexistent in many inner-city areas. Although many physicians in specialized fields continue to maintain offices in downtown Baltimore, they primarily treat nonresidents.

Higher nonwhite mortality rates have been reported consistently by many states. However, the magnitude of this difference has generally not been recognized, since it is masked by age variations in the two racial groups. Since Negroes have a greater proportion of younger residents and a relatively small

number among the aged, age-adjusted and age-specific death rates provide a more accurate and meaningful comparison than crude death rates. Analysis of Maryland data on this basis indicates that Negro mortality rates are substantially higher, particularly in the middle years of life, and that this excess, to a considerable extent, balances the larger nonwhite birth rates. That is, the rate of natural increase does not differ greatly between white and nonwhite residents. A continuing decline in the number of Negro births without a concomitant decrease in deaths could within a few years produce a shrinking proportion of nonwhite Maryland residents.

Procedures designed to minimize differences in mortality rates and provide adequate and appropriate health services to all residents would, we believe, have to be concentrated in Baltimore's poverty areas. While such services would of necessity be primarily publicly operated, they need to provide incentives for local involvement and for participation by all appropriate professional groups. They should also work in close coordination with other programs in related fields and should concentrate on community centered, preventive services. Since the city's sources of taxes are shrinking, funds to provide these needs increasingly will have to come from the state or federal government.

The number of women of child-bearing age is now increasing substantially due to the large number of births in the years immediately following World War II. Even if the fertility rate decreases further, it is probable that the downward trend in births and in the birth rate will halt or even reverse itself in the near future. In fact, data for 1969 indicate a slight increase in the number of live births, although the birth rate continued to decrease. However, the probability that these will return to the high levels of earlier years is, we believe, remote. Opinions vary as to future fertility rate trends. Our personal belief is that the number of higher order births will continue to decrease and that Maryland's rate will decline for some time, most likely around the 3% yearly rate noted in recent years. Should this be correct, the coming increase in the number of women of child-bearing age will produce only a moderate rise in the number of births.

Legislation making abortion a medical decision between the patient and her physician will most likely be reintroduced in 1971. Regardless of the outcome of these efforts, program staff have expressed the belief that the number of hospital-performed abortions will increase for some time. They feel that this will occur because of growing recognition of the availability of this procedure, a willingness by more hospitals to perform this operation, and the commitment of the Department of Health and Mental Hygiene to meet the necessary costs for those women who do not have the required resources. Should the number of abortions reach the rates reported by



some foreign countries, this could have an appreciable impact on the birth rate.

Declining fertility rates among all population groups have important implications. For example, the average occupancy rate of maternity wards in Maryland hospitals is currently approximately 60%, a figure which will probably not rise greatly in coming years. Greater economy and efficiency of operations may therefore be achieved by converting some maternity wards to other uses. Similarly, consideration might be given to amalgamating or redirecting some pediatric services. Construction of elementary schools, a major capital cost of local government, might be limited in most cases to the replacement of obsolete buildings and to building units in new residential areas. This could release funds for the establishment or expansion of other programs. School boards should find recruitment and retention much simpler than in past years while upgrading faculty levels and reducing teacher-pupil ratios.

One direct effect of the reduction in births has already become apparent. Proportionally, the decrease has been greatest in births of fourth or higher order, many of which have been traditionally to mothers in high-risk groups. Maryland's decline in infant mortality rates in recent years in large measure can be attributed to this. It probably has had the same effect elsewhere as well. Further improvement in this popular index in coming years, resulting from a continuing decrease in higher order births, can be reasonably anticipated. In fact, it is quite possible that Maryland will be able to match the record low rates reported by some foreign countries.

One factor which may have major bearing on future health-related programs and services has not as yet been adequately recognized. A few years ago, Maryland reapportioned both houses of its legislature with control passing for the first time from rural to urban areas. Following the 1970 census, the House of Delegates and Senate will again be reapportioned. This time, however, the net result will primarily be a major reduction in the size of Baltimore's delegation and a concomitant increase in representation from the suburban counties. The latter, with almost no voice in state government a few years ago, will now have substantial majorities in both chambers. These men and women will, in many cases, represent recent migrants from Baltimore and Washington who, in part, move to avoid the complexity of problems increasingly evident in these urban areas. This has not only involved a removal from one political subdivision to another; it has also meant a mental and physical separation of considerable magnitude. How cognizant will these individuals and their constituents be of health problems and needs not directly related to them, peculiar to the inner-city and mainly involving members of another racial group? Will they vote increased taxes which may be required to produce

funds needed for developing and providing appropriate health resources?

Maryland has long been in the forefront in the introduction of many health-related concepts and services. The Johns Hopkins University School of Hygiene and Public Health, for example, recently celebrated the 50th anniversary of its establishment and is the oldest facility of its type in the United States. Maryland has been a leader in the provision of locally administered health services. These efforts have been aided by the presence within the state of two medical schools and the National Institutes of Health. Despite this, public health programs apparently have failed to reach some population segments. Mortality rates have not been reduced in recent years and the prevailing major white-nonwhite differences have not been diminished. This is an indictment shared with many other states. A speaker at a recent dinner in Annapolis of our State Mental Health Association felt that the quality of Maryland's publicly operated psychiatric facilities is poor, which is typical of most states. He chose as the title of his talk, "Maryland, My Mediocre Maryland", a parody of the state song, "Maryland, My Maryland". While this is probably a good description of existing services, it also reflects the need for remedial action.

One indication that Maryland now is committed to the principle of uniformly high levels of health services for all residents, in the most effective and efficient manner possible, has been the establishment, as of July 1, 1969, of the Department of Health and Mental Hygiene. Its jurisdiction includes responsibilities formerly carried out by a large number of independent departments and boards. This, for the first time, centralizes planning for, and administration of, all health-related programs. The department, with imaginative leadership, will have the opportunity and ability to establish innovative services which can convert the state's commitment to reality.

### Summary

Maryland, a state bordering on the north and south, has many of the characteristics of the total United States. Its rapid population growth has been concentrated largely in suburban areas. At the same time, selective migration has led to a concentration in Baltimore of the state's community dependent. Both trends are expected to continue for some time.

Baltimore's inner area has lost many health facilities and services. This is expected to intensify existing problems. One indication of these is the high nonwhite death rates in all age groups and from all major causes of mortality. Birth rates have been falling for some time. Although a rapid increase in the number of women of child bearing age may lead to a reversal of this trend, the rise is expected to be moderate.



# **your medical faculty at work**

by John Sargeant  
Executive Director

The Executive Committee met on Thursday, January 14, 1971, and took the following actions:

1. Adopted a proposed 1971 budget for recommendation to the Council;
2. Determined that financial considerations prevented employing an individual to serve as a replacement for the Executive Director in case of illness or death, and determined that the Faculty could adequately function until such a time as a replacement could be employed;
3. Adopted a policy that the Executive Director should obtain an annual "executive type" physical examination at Faculty expense;
4. Adopted a policy that all new employees receive a preemployment physical at Faculty expense;
5. Adopted certain recommendations to the Council to be submitted to the Blue Shield board for consideration by its nominating committee;
6. Authorized submitting names to the Governor for appointment to the Medical Board for Occupational Diseases;
7. Heard that the Maryland Nurses Association had adopted the nurse-midwife protocol as previously approved by the Faculty;
8. Determined to take no specific action on a FDA communication regarding certain drug withdrawals, since the FDA has already sent this data to physicians;
9. Went on record as opposing any quota system for admission to colleges; and also called for intensified efforts to enroll larger numbers of disadvantaged minorities, if they are qualified for admission to the college;
10. Authorized designation of J. Roy Guyther, MD, of Mechanicsville, to serve on a special committee named by the Chancellor of the University of Maryland to determine the need for a training course for physician assistants; and to serve on a curriculum committee, if this committee makes such a determination;
11. Authorized submitting a list of names to the Advisory Council on Hospital Construction, for appointment by the Secretary of Health and Mental Hygiene.





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




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## Doctors Take Note . . .

*(Continued from page 52)*

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### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Gynecologic Peritoneoscopy: Chicago, Illinois. Contact: Cook County Graduate School of Medicine, 1707 S. Wood St., Chicago, Illinois 60612.

**MARCH 15-26, 1971**

### **ABRAHAM LINCOLN SCHOOL OF MEDICINE**

Postgraduate Course—Laryngology and Bronchoesophagology: Medical Center of the University of Illinois, Chicago, Illinois. Contact: Department of Otolaryngology, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

**MARCH 17, 1971**

### **AMES COMPANY, DIVISION OF MILES LABORATORIES, INC.**

Second International Symposium on Early Disease Detection: University of Chicago, Center for Continuing Education, Chicago, Illinois. Speaking are physicians from Japan, Sweden, the United Kingdom, Hawaii, and the U.S. There is no registration fee; advance registration is requested. Write: Morton B. Stone, Symposium Coordinator, 3553 West Peterson Avenue, Chicago, Illinois 60645.

**MARCH 18-20, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Recent Developments in Obstetrics and Gynecology: New York, New York. For further information, write: Page and Wm. Black Postgraduate School of Medicine of the Mt. Sinai School of Medicine, 5th Ave. and 100th St., New York, N. Y. 10029.

**MARCH 18-20, 1971**

### **AMERICAN BAR ASSOCIATION/AMERICAN MEDICAL ASSOCIATION**

National Medicolegal Symposium: Americana Hotel, New York city. Write: Liaison Committee to ABA, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

**MARCH 19-21, 1971**

### **COUNCIL OF EDUCATION AND SCIENCE, PENNSYLVANIA MEDICAL SOCIETY**

Conference—Medical Education Administration: Hotel Hershey, Hershey, Pennsylvania. Registration fee: \$65. AAGP, ACP credit applied for; AMA credit: 13 hours. Write: Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pennsylvania 17043.

**MARCH 25-26, 1971**

### **AMERICAN MEDICAL ASSOCIATION**

24th National Conference on Rural Health: Atlanta Marriott Motor Hotel, Atlanta, Georgia. Contact: American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

**MARCH 31, 1971**

### **COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH, MEDICAL AND CHIRURGICAL FACULTY/ST. JOSEPH HOSPITAL**

Symposium—Emergency Room Medicine: St. Joseph Hospital, Towson, Maryland. Contact: Medical and Chirurgical Faculty, 1211 Cathedral St., Balto., Md. 21201, or call 301-539-0872.





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### NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Allen, Peter Charles

**A clinical guide to intravenous nutrition.** By P. C. Allen and H. A. Lee. With a section on its use in surgery by Harold Ellis and paediatrics by G. H. Hadfield. Oxford, Edinburgh, Blackwell Scientific, 1969.

American Academy of Orthopaedic Surgeons. Committee on Sports Medicine.

**A bibliography of sports medicine.** Jack C. Hughston and Kenneth S. Clarke, editors. Chicago, 1970.

Aust, Wolfram

**The conservative management of squint.** Translated by C. H. Bedwell and H. Obstfeld. Basel, Munchen, New York, S. Karger, 1970.

Bredow, Miriam

**The medical assistant; a guide to clinical, secretarial and technical duties.** By Miriam Bredow and Marian G. Cooper. 3d ed. New York, McGraw-Hill, 1970.

Burack, Richard

**The new handbook of prescription drugs; official names, prices and sources for patient and doctor.** [Rev. ed.] New York, Pantheon Books [1970].

Caldwell, William L.

**Cancer of the urinary bladder, with emphasis on treatment by irradiation.** St. Louis, W. H. Green [1970].

Chusid, Joseph G.

**Correlative neuroanatomy and functional neurology.** 14th ed. Los Altos, Calif. Lange Medical Publications, 1970.

Duncan, Garfield George

**Diseases of metabolism.** With contributions by Margaret J. Albrink [and others]. Edited by Philip K. Bondy in association with Leon E. Rosenberg. 6th ed. Philadelphia, Saunders, 1969.



Eckenhoff, James E.

**Anesthesia from colonial times;** a history of anesthesia at the University of Pennsylvania. Montreal, Philadelphia, Lippincott, 1966.

Fishbein, Morris

**Morris Fishbein, M.D.,** an autobiography. Garden City, N.Y. Doubleday, 1969.

Gable, Fred B.

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## tuberculosis

# Progressive Disseminated Histoplasmosis as Seen in Adults

Once local host resistance is overcome, hematogenous dissemination of the histoplasma spores may occur. Amphotericin B provides the most effective means of combating the infection. Most properly managed patients can tolerate this drug even for prolonged periods.

In the present review, case records of 530 adult patients with diagnosed histoplasmosis over a 13-year period (1955-1968) were studied for the dual purpose of ascertaining the extent of progressive disseminated disease and the therapeutic efficacy of amphotericin B.

Twenty-five patients from 16 to 75 years of age were found to have progressive disseminated histoplasmosis. The largest number (8, or 32%) were within the sixth decade of life. Males predominated (12.5:1). One patient was a Negro; 24 were white.

Fifteen (60%) were farmers or had lived on farms for many years. One patient developed symptoms within three months after becoming a driver of manure-hauling equipment. One patient owned a pet shop.

The commonest symptoms in the group included fever, cough, dyspnea, fatigue, weakness, anorexia, and weight loss.

The demonstration of *H. capsulatum* was the most important criterion for inclusion in the study. This was achieved by differential staining of the tissue sections with methenamine silver stain as modified by Gomori.

In the encapsulated lesions the organisms were usually found in great numbers in the centers where re-

cent caseation had developed. In the tissue, the intracellular organisms appeared as small or oval yeast-like bodies, measuring from  $1\mu$  to  $5\mu$ . Extracellular forms as large as  $10\mu$  to  $15\mu$  were also noted in the necrotic tissues.

Additional confirmation was obtained by isolation and identification of the organism from tissue cultures. Animal inoculation and pathogenicity studies were also performed in a few isolates. Dissemination of the disease was presumed when more than one organ was found to be involved.

Most investigators believe that the natural route of histoplasmosis is through the respiratory tract by inhalation of spores. In at least one of five patients with gastrointestinal involvement in the present study, however, spores appear to have gained entry through the gastrointestinal tract. While widespread involvement of the peritoneum, the mesenteric glands, spleen, and adrenals was found at necropsy, extensive search of the lungs and chest X-ray failed to reveal active or healed lesions.

More characteristically, 19 of the 24 patients tested had positive sputum cultures for *H. capsulatum*. Roentgenograms of the chest varied: two patients had no evidence of pulmonary disease, active or healed; five had diffuse calcified lesions; one showed miliary calcification; eleven had cavitary lesions, and six had pulmonary infiltration without cavitation.

Prathapchandra Reddy, MD; David F. Gorelick, MD; Charles A. Brasher, MD; Howard Larsh, PhD. The American Journal of Medicine, May, 1970 (Vol. 48).



Whichever the portal of entry, once the local host resistance is overcome, hematogenous dissemination may occur.

Five patients, for example, with typical histoplasmosis in the oral cavity were later found to have disseminated disease in other organs. One of these patients, hospitalized for histoplasmosis of the palate and larynx, was found to have disseminated disease of the ileum on operation for acute intestinal obstruction. The constricting lesion was positive for *H. capsulatum* on stain and tissue culture. He improved with amphotericin B and is well three years after treatment.

Oral lesions of histoplasmosis may mimic tuberculosis, syphilis, Hodgkin's disease, and other lymphomas, Vincent's, and other fungal infections. Biopsy for demonstration of the specific organism should be undertaken in all suspicious lesions.

It is not generally appreciated that histoplasmosis, both in its acute and chronic stages, can involve the heart and great vessels. One case of pericardial effusion due to histoplasmosis in one of the study patients was reported earlier (1961). A second patient in this series had possible pericardial involvement as well.

Six patients had positive urine cultures for *H. capsulatum*, and four of these patients had azotemia (with blood urea nitrogen levels  $> 25$  mg/100 cc) prior to therapy.

However, on necropsy only one patient was found to have renal involvement. This suggests that patients with extrarenal histoplasmosis without renal disease pass *H. capsulatum* in urine.

In the one patient with renal disease, lesions were bilateral and there were several small foci localized mainly to the glomeruli and tubules in the cortex. *H. capsulatum* were also isolated from the liver, spleen, and adrenal glands of this patient.

Another patient had vesical and prostatic involvement. Grossly, the bladder was rough, thick-walled, with multiple ulcerations. Microscopic examination demonstrated *H. capsulatum*. Tissue cultures of the bladder, prostate, adrenals, and lungs were positive.

Other areas of involvement included the liver (in two patients), the spleen (in six), the adrenal glands (in eight), and the skin (in two).

Lymph nodes are frequently involved in the inflammatory process of this disease. Extrathoracic lymph-node involvement may result from generalized dissemination via the blood or lymph stream. Regional nodes into which an infected organ drains may also become infected.

In the present review, 17 cases of extrathoracic lymph-node involvement was demonstrated, including four cases of involvement of the mesenteric nodes, five of the scalene nodes, two of the cervical nodes, four of the inguinal nodes, and two of the submandibular nodes.

Blood cultures were positive in 13 of 22 and bone marrow cultures in 15 of 23 patients. Since all histoplasmosis in the study was found to be disseminated through the blood stream, negative cultures probably mean that at the time of testing there were no circulating organisms.

### Treatment

Amphotericin B has been found to be the most effective drug in the treatment of histoplasmosis when adequately employed. Adequate treatment consists of 1 mg dose/kg of body weight each day, or a total dose of 40 to 50 mg each day, injected intravenously three times weekly after a gradual buildup from a low initial dosage of 10 to 20 mg each day.

Of the 14 patients with disseminated histoplasmosis who had received adequate treatment over the past 11 years, only one (7%) has died from histoplasmosis. In contrast, all three patients (100%) who did not receive amphotericin B died from it.

With proper management most patients can tolerate the drug, even for prolonged periods. Minimum adequate coverage for active histoplasmosis was found to be a total dose of 25 mg/kg. Higher total dosages (40 to 50 mg per kg) are recommended for more serious forms of the disease.



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# occupational and environmental health news

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In this departmental page, we intend to discuss up-to-date information which will be useful to all physicians interested in, or practicing occupational and environmental health. We hope this information will stimulate the Faculty members to become more active in this health field. This is particularly important nowadays in view of the public's continuing emphasis on the quality of the environment.

We hope to serve as informal consultants to any physician who may have a problem in the occupational health area, either related to his work within industry, or in private practice. Therefore, we welcome any requests for information, any questions, and any suggestions. They will be answered through this page for the benefit of the majority.

### Placement Service

By this time, most of you have returned the questionnaire mailed out last November concerning your interest in working in the occupational health field. The state of Maryland has a great need in this area and this is a good opportunity for all physicians to demonstrate their involvement with the employee health programs within the state.

The placement service will attempt to bring together those physicians who are interested in providing industrial medical services, and those industries which are in need of services. We expect to operate this program on a temporary basis, until the Occupational Health Division of the State Health Department is able to take over this function. So, if you haven't returned your completed questionnaire please do so, as soon as possible.

### Round-Table in Occupational Health

Plan to attend the round-table discussion in occupational health at the annual luncheon which is scheduled for Thursday, May 13, 1971 at 12:30 PM during the Faculty's annual meeting. The moderator will be announced later and will also be listed in the annual program. This is an unique opportunity for physicians to bring special problems they

have encountered working in industry in any capacity, and have their questions answered.

### Air Quality Notes

All of you have probably read about the new air quality regulations already in effect in Montgomery and Prince George's counties. Similar regulations are being developed for the metropolitan Baltimore area. The aim is to eliminate all visible smoke or emissions from heating or burning facilities. Small incinerators will also be gradually eliminated, as well as open burning for clearing land. These limitations, which will be enforced by the state and county health departments, are said to be the strictest in the nation.

Air pollution is certainly one of today's biggest problems, and a problem which was reviewed in considerable detail at the Second International Clean Air Congress held during the week of December 7 at the Sheraton Park Hotel in Washington, D.C.

During the presentation of a paper on "Asbestos Air Pollution" in New York city, it was indicated that asbestos pollution in the city is quite high. In an effort to control some of the pollution, very stringent regulations for the spraying of asbestos in the construction industry have been adopted. It was emphasized that this is only an interim measure and that the spraying of this material will probably be completely prohibited in the future. It was also mentioned that considerable quantities of asbestos from steel girder spraying operations were found as far as ten blocks away from the construction site.

Various types of air-monitoring instruments were on display during the congress in the exhibit area. Several dual or multipurpose measuring devices were shown. Some use a basic read out meter with plug-in modules which have been developed for specific contaminants. One multicomponent analyzer continually measures and records sulfur dioxide, nitric oxide, nitrogen dioxide, and ozone concentrations. It could also be adopted to measure several other air contaminants.



The control of sulfur dioxide emissions was a big topic of discussion. There was considerable interest in a new control system which promises to regenerate its own chemical feed requirements, avoid disposal problems, and perhaps also make a profit (by the production of sulfuric acid). A portable sulfur dioxide analyzer weighing less than 6 lb and operating on the same principle as very large laboratory models was demonstrated. Another portable sulfur dioxide air monitor (approximately 7 inches by 7 inches by six inches) had a built-in recorder and is not supposed to be sensitive to usual interfering gases. It was also designed to measure sulfur dioxide in aqueous solutions (pharmaceuticals, foods, beverages, etc.).

A portable automatic dust counter designed for use in mines was displayed. A competitive company showed a similar light-scattering instrument which uses a condensation nuclei approach to increase its lower limit of detectability to particles  $0.001 \mu$  in diameter.

One company representative discussed their capability of controlling odoriferous gases by using potassium permanganate. It was said to have been successfully used in sewage-treatment, rendering, asphalt, and fish and chicken processing plants.

Representatives of another firm discussed a somewhat different approach aimed at resolving pollution problems. In an effort to help high school students

cope with their polluted environment, a complete course in pollution problems and solutions was developed. The program is based on a unique set of experiments and apparatus. If this type of approach had been taken several years ago, perhaps today's pollution problems could have been avoided.

#### Medical Follow-up in Occupational Health Clinic

Recent studies in the NASA Goddard Space Flight Center Health Clinic have shown that continued follow-up of medical conditions should be an integral part of the occupational health program for employees. The results, to be published soon, reveal a significant decrease in mortality and disability among a group of hypertensives treated by their private physicians and receiving regular follow-up care in the health clinic. Another group receiving treatment, but no follow-up, had poor control of their hypertension.

The combination of private physician care and employee health clinic follow-up is one way to relieve the private physician of excessive office work load, so that he can spend more time in actual treatment. The preventive aspects of follow-up are carried out in the employee health clinic. This combination insures high quality care and results in the improvement or correction of the medical conditions under treatment.

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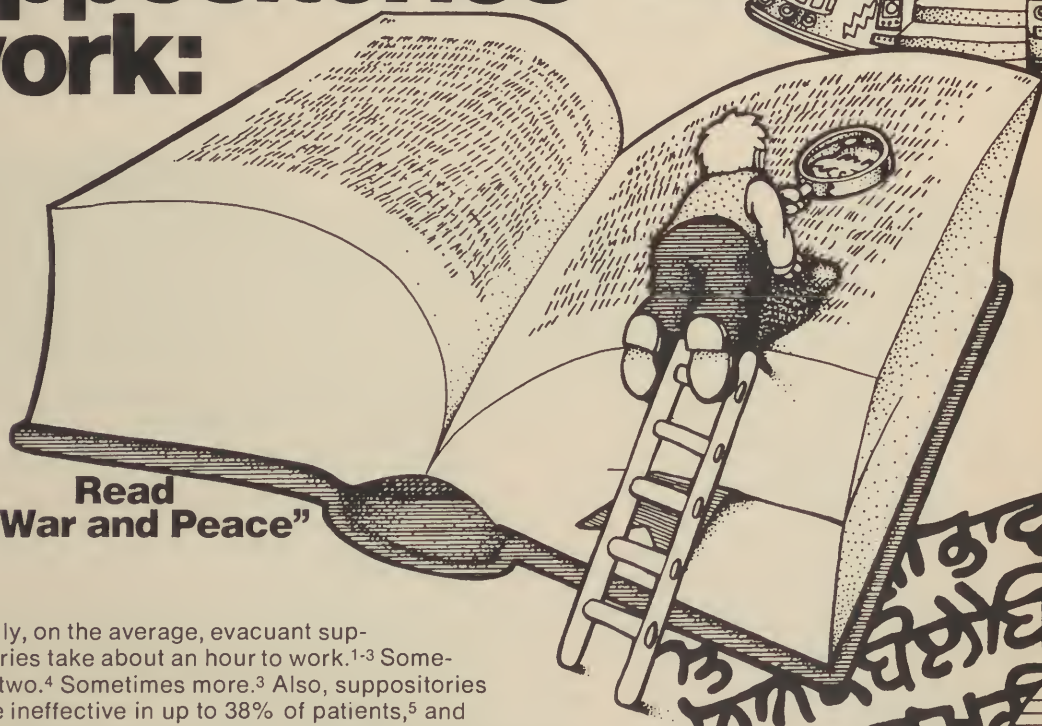
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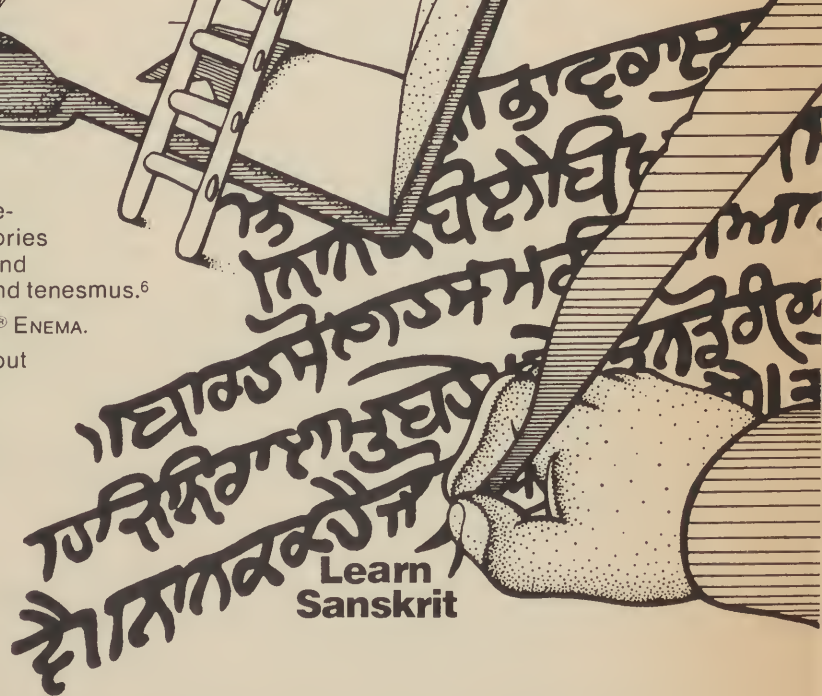
Actually, on the average, evacuant suppositories take about an hour to work.<sup>1-3</sup> Sometimes two.<sup>4</sup> Sometimes more.<sup>3</sup> Also, suppositories can be ineffective in up to 38% of patients,<sup>5</sup> and not infrequently produce smarting, burning and tenesmus.<sup>6</sup>

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**References:** 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriatr Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.

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Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three months before gradually receding. Since this response is so predictable, lesions which do not respond should be biopsied.

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Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings

and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

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**Warnings:** If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

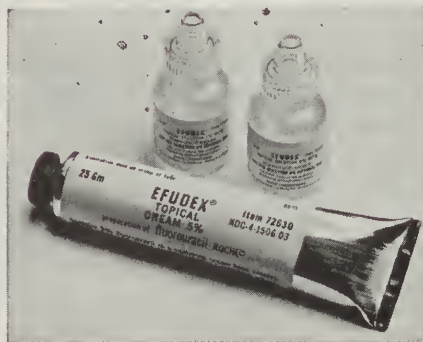
**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

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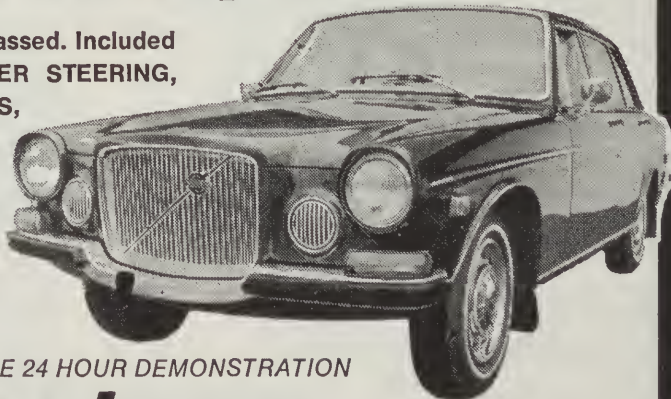
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## Baltimore City health department

# Mobile Dental Units Planned

The Baltimore City Health Department has received a grant of \$300,000 from the Model Cities Agency for the purchase of six Mobile Dental Units. There will be two operatories in each Mobile Dental Unit incorporating the most modern design for the most effective and productive use of the professional staff.

In approving the grant, the United States Department of Housing and Urban Development expressed concern regarding the potential for maximum use of the six Mobile Dental Units. It stated that "it seems the Mobile Dental Units should be in use at least six days a week, with both day and evening hours." To operate the Mobile Dental Units these hours will require a budget of more than \$600,000 a year. This sum has been requested from the Model Cities Agency.

Each of the six Mobile Dental Units will be staffed with one dentist, two dental assistants, and a receptionist-secretary. Due to the unavailability of "qualified" dental assistants in general, and in the Model Cities Area in particular, it will be necessary for the Baltimore City Health Department to develop and conduct a six-month dental assistant training program.

Comprehensive dental care will be available to

all residents of the six Model Cities areas. There will be one Mobile Dental Unit in each of the six areas at all times. The main locations will be the 35 Baltimore city elementary schools which do not have dental clinics, and the area council offices, housing projects, and other convenient locations.

Each Mobile Dental Unit should be able to provide for at least 25 to 30 dental visits each day or a total of more than 50,000 dental visits for all six Mobile Dental Units each year. This would allow for approximately one visit each year for nearly one half of the Model Cities area residents. This, of course, is based on the premise that the Mobile Dental Unit facilities will be in continuous use during scheduled hours.

The new program planned to be in operation by May 1971 supplements the year-old Model Cities-City Health Department cooperative community preventive dentistry program in which 50,000 children and many parents have participated. It is being coordinated with the department's ongoing preventive and treatment program begun in 1950 by H. Berton McCauley, DDS, Director of the Bureau of Dental Care. The Model Cities-health department dental programs are under the supervision of Carl B. Holmes, DDS.

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## Rural Mental Health Centers

What is the outlook for better mental health care for Americans living in the rural areas of the nation? Due to a federally funded community mental health program, it is brighter than at any time since the rise of the large custodial mental hospital.

In a recent tabulation of the growing number of community mental health centers, the National Institute of Mental Health reports that centers are now slated for 23% of the country's rural county population. These centers will bring mental health services within reach of millions of Americans, most of whom never before had access to community-based care and alternatives to hospitalization.

In 11 states, centers to be created with the aid of federal construction and staffing grants will cover more than one third of their rural county populations.

Among the states with the highest mental health service coverage for rural county residents, based on grants awarded up to early 1969, are: Kentucky, 88%; North Dakota, 63%; and Vermont, 44%. Colorado, Massachusetts, Montana, and Michigan range from 39% to 42%. Pennsylvania, Florida, New Hampshire, and South Carolina range from 33% to 38% coverage.

Since the first federal grant for community mental health centers was awarded in 1965, more than 350 centers have been funded in 49 states, Puerto Rico, and the District of Columbia, covering areas in which more than 54 million Americans reside. By 1980, some 2,000 centers are projected by the national community mental health program.

National Institute of Mental Health

## Brain Damage

Every time a person takes a few drinks of an alcoholic beverage, even a few beers or cocktails at a social function, he permanently damages his brain, and probably his heart and liver.

Glenn D. Everett—*Listen*, Dec. '69

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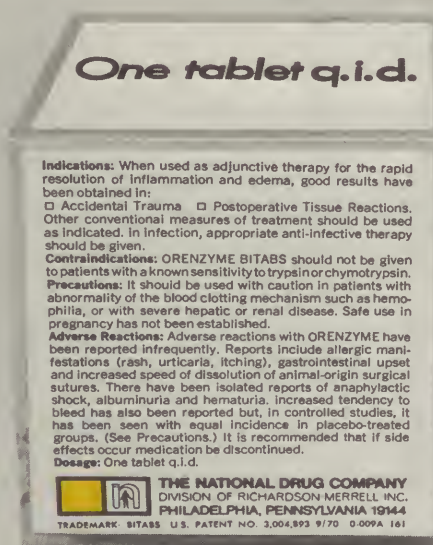
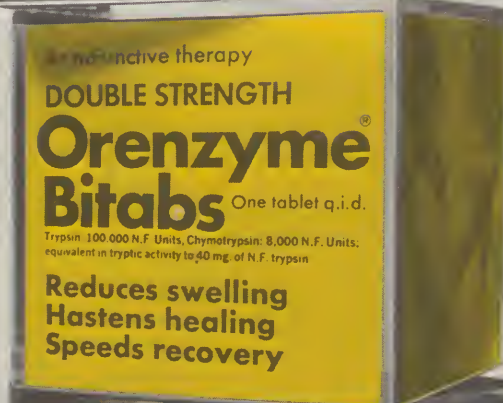
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MIRIAM L. COHEN, MD, EDITOR

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## the heart page

# Antibiotic Treatment of Bacterial Endocarditis

JOHN H. MULHOLLAND, MD

Assistant Chief of Medicine  
Union Memorial Hospital  
Assistant Professor of Medicine  
The Johns Hopkins Hospital  
Baltimore

In bacterial endocarditis, identification of the specific bacterial pathogen is most important in selecting the proper antibiotic regimen and the appropriate duration of therapy. Usually, five blood cultures obtained over a 24-hour period will provide a 95% chance of establishing the offending pathogen.

It is imperative that *bactericidal* antimicrobial agents (the penicillins, cephalothin, vancomycin, streptomycin, kanamycin, gentamycin, and the polymyxins) be used in treating bacterial endocarditis, since bacteriostatic agents (erythromycin, lincomycin, tetracyclines, chloramphenicol, and sulfanomides) may suppress, but not eradicate, the infection. Selection of specific agents depends upon the pathogen discovered, with antibiotic disk and tube dilution sensitivities providing more exact guidelines. For effective treatment, sufficient amounts of the antibiotic agents must be administered to achieve a serum bactericidal activity which will kill the infecting microorganism at a 1:4 dilution or greater.

Serum bactericidal activity is determined by testing the killing effect of serial twofold dilutions of the patient's serum inoculated with the organism isolated. Serum levels of this magnitude should be maintained for four to six weeks, making parenteral therapy almost a requirement. If oral therapy is used, or if the pathogen is one which is known to be difficult to eradicate, measurement of serum bac-

tericidal levels should be done to establish adequate drug dosage.

### Streptococcal Endocarditis

Approximately three quarters of causative organisms will be found in this group of bacteria which are usually associated with the subacute form of endocarditis.

**Streptococcus viridans and other nonenterococcal endocarditis ("Penicillin sensitive"):** The great majority of these organisms are highly susceptible to penicillin (killed by 0.1  $\mu\text{g/ml}$ ; will demonstrate a large zone of inhibition when treated in vitro with a two-unit penicillin disk). Caution must be applied in interpretation of in vitro penicillin disk results; attention must be paid to the concentration of antibiotic, as well as to the technique for measuring sensitivity or resistance. Patients with these "highly sensitive" strains should receive approximately 5 million units of PCN parenterally for four weeks. Some authors favor simultaneous therapy with 0.5 gm of streptomycin every 12 hours for the first



two weeks. Patients who are allergic to penicillin may be treated with 2 gm of cephalothin given intravenously every four to six hours.

**Streptococcus fecalis or enterococcal endocarditis ("Penicillin resistant"):** All strains are relatively resistant to penicillin and, hence, may be inhibited but not killed by penicillin therapy alone. Despite the fact that these organisms are relatively resistant in vitro to penicillin and are highly resistant to streptomycin, these drugs in combination have a synergistic effect. Twenty million units of penicillin-G in combination with 2 gm of streptomycin administered intramuscularly daily for the first two weeks, followed by 1 gm daily for six weeks is the recommended regimen. Serum bactericidal activity should be monitored. Twelve grams of ampicillin a day may be substituted for penicillin, but it seems to offer no advantage. In patients allergic to penicillin, 0.5 gm of vancomycin given intravenously every six hours may be employed in combination with streptomycin (there is little experience with this regimen).

#### **Staphylococcal Endocarditis**

*Staphylococcus aureus* will be the causative organism in approximately 10% to 15% of endocarditis cases, being responsible for about 50% of acute bacterial endocarditis. A high incidence is found in drug addicts with endocarditis. This organism will be responsible for most endocarditis which arises on prosthetic cardiac valves. Initial therapy, when this pathogen is suspected or proven, should be methicillin (or other penicillinase resistant semisynthetic penicillin) 8 gm to 12 gm daily. If the staphylococcus is inhibited by 1  $\mu\text{g}/\text{ml}$  of penicillin (significant zone of inhibition around a two-unit disk) 20 million units of penicillin-G daily, administered intravenously, should be substituted. Therapy should be continued for six weeks. In patients allergic to penicillin, 2 gm of cephalothin given intravenously every four hours or 0.5 gm of vancomycin intravenously every six hours is a suitable program.

#### **Pneumococcal Endocarditis**

Pneumococci, which account for less than 5% of endocarditis cases, arise in patients with pneumonia or meningitis and may cause rapid damage to the heart valves. Parenteral penicillin should be administered in a dose range of 5 million units daily for four weeks. In patients allergic to penicillin, 2 gm of cephalothin given intravenously every four to six hours may be substituted. Successful therapy has been reported with other antibiotics (lincomycin, erythromycin).

#### **Candida Endocarditis**

Endocarditis associated with candida septicemia has become more frequent, occurring in drug addicts,

persons treated with multiple antibiotics, and patients with prosthetic valves. Amphotericin-B, 0.5 to 1.0 mg per kg daily for eight to ten weeks, is the treatment of choice.

#### **Blood Culture Negative Endocarditis**

Despite improved culture techniques and awareness that cultures should be kept three weeks before being discarded, about 10% of endocarditis cases will have negative blood cultures. Sometimes suitable cultures may not have been obtained prior to antibiotic therapy. These patients are certainly the most difficult to treat. I favor therapy as outlined for enterococcal endocarditis (high dose intravenous penicillin and streptomycin). Because of the increasing number of cases with penicillinase-producing staphylococcus, one has to consider the addition of 2 gm of methicillin administered intravenously every four hours, if the patient fails to show improvement.

#### **Recurrent Endocarditis**

Patients who suffer a recurrence of endocarditis either months or years after their initial infection should be treated as previously described for the specific bacterial pathogen isolated. Most physicians would prolong the course of parenteral antibiotic therapy in the event of early recurrence.

#### **Penicillin Hypersensitivity**

Penicillin is certainly the cornerstone of therapy for endocarditis and every effort should be made to include this agent in the treatment regimen. In patients reporting allergy to penicillin, particularly a delayed type of allergy, an attempt should be made at desensitization. If a penicilloyl-polylysine skin test is available and is negative, it is likely that the patient will not have an immediate reaction. Progressively increasing doses of subcutaneous penicillin, beginning with 0.01  $\mu\text{g}$  of penicillin-G and increasing tenfold every 20 to 30 minutes (if there is no reaction), should be administered. After the 10 mg (10,000  $\mu\text{g}$ ) dose, the drug may be given slowly intravenously. Diphenhydramine hydrochloride (*Benadryl*) may be used in the event of minor reactions. Once therapy is begun, it should not be interrupted for any significant period of time.

#### **Prophylaxis of Bacterial Endocarditis**

In patients with abnormal heart valves, in whom there is a predisposition for bacterial endocarditis, prophylactic antibiotics should be administered in association with procedures which might result in bacteremia. Patients undergoing dental procedures (extractions, repair, extensive cleaning) should receive 600,000 units of procaine penicillin one hour before the procedure and once daily on the subsequent two days. Oral penicillin 400,000 units four times a day *might* be an adequate substitute, if 600,-



000 units of intramuscular procaine penicillin is given one hour before dental treatment. In patients allergic to penicillin, 0.25 gm of erythromycin four times a day may be used.

For genitourinary procedures or rectal surgery, prophylaxis should be directed toward the enterococcus and include: 1.2 million units of procaine

penicillin one hour before and every six hours after the procedure to continue for 72 hours. In addition, 0.5 gm of streptomycin should be given one hour before and every 12 hours for a similar period of time. Erythromycin (0.25 gm) every six hours may be substituted for penicillin in penicillin-allergic patients.

#### Treatment of Bacterial Endocarditis

Type of Endocarditis	Antibiotic Treatment		Comment
	Of Choice	PCN Allergic	
<b>I. Streptococcal Endocarditis</b> PCN sensitive endocarditis <sup>1</sup> (viridans, group A, microaerophilic, anaerobic)	PCN 5,000,000u parenteral for four weeks	Cephalothin 8 gm to 12 gm IV daily	Short course therapy (two weeks) with addition of SM 0.5 gm q12hr has been advocated by some authors.
	PCN 20,000,000u parenteral/day SM 1 gm IM q12hr for two weeks followed by SM 0.5 gm IM q12hr for four weeks. Total of four to six weeks of therapy	Vancomycin 0.5 gm IV q6hr with or without SM. (There is little experience with this regimen.)	
<b>II. Staphylococcal Endocarditis</b> PCN sensitive endocarditis <sup>2</sup>	PCN 20,000,000u IV/day for six weeks	Cephalothin 8 gm to 12 gm IV/day	Ampicillin 12 gm/day has been substituted for PCN but currently offers no advantage.
PCN resistant endocarditis <sup>4</sup>	Methicillin 8 gm to 12 gm IV/day or other semi-synthetic parenteral PCN for six weeks	Cephalothin 8 gm to 12 gm IV/day or Vancomycin 0.5 gm IV q6hr/day	
<b>III. Pneumococcal Endocarditis</b>	PCN 20,000,000u IV/day for four weeks	Cephalothin 8 gm to 12 gm IV/day	
<b>IV. Candida Endocarditis</b>	Amphotericin-B 0.5 to 1 mg/kg/day for eight to ten weeks		Dosage must be adjusted according to extent of renal damage.
<b>V. Endocarditis with Negative Blood Culture</b>	Treatment as for PCN resistant streptococcal endocarditis (above)		In addicts and post cardiac surgery patients methicillin may have to be added because of the likelihood of resistant staphylococcus.

<sup>1</sup> killed by 0.1 µg/ml of PCN

<sup>2</sup> not killed by 0.1 µg/ml of PCN

<sup>3</sup> killed by 1 µg/ml of PCN

<sup>4</sup> not killed by 1 µg/ml of PCN

PCN—penicillin  
SM—streptomycin  
IM—intramuscular  
IV—intravenous

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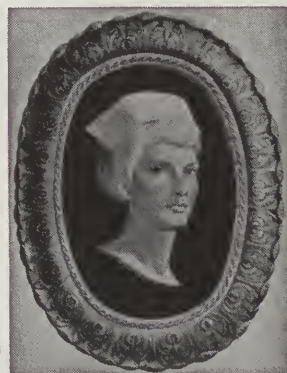
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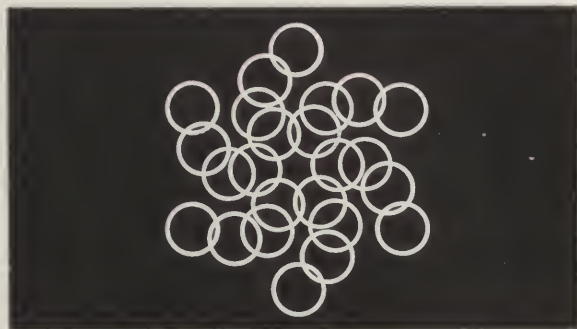
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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# How to Take a History on an Alcoholic

**MICHAEL SHENKHAM, MD**  
General Practitioner on Alcoholism  
Westwood, New Jersey

Most physicians do not like to handle alcoholics. One reason is that it is confusing to develop a history that will cover the ground adequately and compactly; give proper weight to ecologic, sociologic, and familial factors; and offer a systematic and not too time-consuming way of getting the needed history. The form offered below has developed out of my experience as medical director of the Alcoholism Treatment Center at Bergen Pines. The physician who conscientiously follows a form like this will:

- (1) Face the alcoholic in his office as he does any other patient—with a systematic history-taking approach;
- (2) Bring out the existence of factors, if any, which would justify referring the patient to a psychiatrist or to a special clinic;
- (3) Facilitate follow-up;
- (4) Enable a trained non-physician in the office or social agency to get a compact, usable set of data on the alcoholic; and
- (5) If used in the hospital, substantially aid the resident, intern, and attending physician to gain a three-dimensional view of a patient with an alcohol problem.

The form may be used as a simple check list or guide, the physician having it on a card or set of sheets which he keeps on his desk or in his bag; or, it may be printed or otherwise reproduced with

enough spaces for writing in the answers. It then becomes a history-form.

### Identifying Data

- Name and address?      Occupation?  
Marital Status?      (Note especially if married after divorce, or if separated)
- How long at present address? (Note if patient moved frequently)
- Does patient live (a) alone? (b) with parents? (c) with spouse? (d) with other relatives? or (e) with friends?
- How did patient happen to come for this appointment? Was it self-referred?
- Or referred by spouse, physician, relative, clergyman, police, social worker, labor union, AA, clinic, friend, or whom?

### Complaints

- Patient's chief complaint—own words.  
Does drinking bother him, or bother someone else?  
Complaints other than the drinking?  
Since when has he been drinking?  
Since when has he considered it a bother or a problem?
- Any previous effort to get help? How, what help, and what luck with it?
- Any experience with AA (Alcoholics Anonymous)?  
To whom has he confided his problem?

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### **The Pattern of Drinking**

Does he drink: alone? at home? at taverns or bars?  
at friends' homes?  
Does he drink with: spouse? friends? relatives?  
strangers? co-workers?  
How much does he drink?  
What kinds of beverages (wine, whiskey, beer, and so  
forth)?  
Does he feel an "urgency" to drink?  
If he abstains when he feels the need, what happens?  
Does he drink slowly? or does he gulp?  
Does he chew or suck lozenges or anything to dis-  
guise the odor of alcohol?  
Over the years has he become more or less tolerant  
of alcohol?

### **Reasons for Drinking**

Why does he drink?  
What does alcohol mean to him?  
How would he define social drinking?  
Does he enjoy the company of friends without drink-  
ing?  
Does he drink for self-encouragement?  
Does he drink to do a better job?

### **Changes In Pattern**

When, where, and how did he have his first drink?  
Has there been a change in his way of drinking dur-  
ing the years?  
Does he have control of his drinking?  
While with friends, and while drinking, could he stop  
while the others continue to drink?  
Does he feel he has to have a drink every day? twice  
a day?

### **Subjective Symptoms**

How often does he get drunk?  
Does he have feelings of guilt because of drinking?  
Does he remember next day what happened during  
or after an episode of drunkenness?  
Does he visit friends in their home?  
Could he tell how he behaves during an episode of  
drunkenness?  
Does he suffer from hangover next morning?  
What does "hangover" mean to him?  
Does he look for a drink to get rid of it?  
Does he have "the shakes" next morning? How does  
he get rid of them?

### **Family Aspects**

Does his spouse approve of his drinking?  
How does he (she) react to his drinking?  
Does he usually agree to her (his) suggestions for  
reducing or stopping drinking altogether?  
How successful was he?  
Are there arguments at home because of his drinking?

Do such arguments make him angry, furious, guilty,  
resentful, defensive, aggressive, or humble?  
Would he say that he is covering up guilt feelings?  
How does his spouse react in an argument?

### **Patient's Own Family**

Did his father drink? How much? Was he a strict  
parent? Did he ever beat him? If he is deceased,  
how old was the patient when his father died?  
Did his mother drink? Was she over-indulgent with  
the patient? If she is deceased, how old was the  
patient when his mother died?  
As he recalls them, were his parents affectionate or  
quarrelsome with each other?  
Would he say that he had any alcoholics among his  
brothers, sisters, parents, or grandparents?  
How does he get along with his brothers and sisters?  
Did he have a happy childhood?  
Would he say that he got pretty bad breaks in early  
life?

### **Community Aspects**

Did his socializing diminish because of his drinking?  
Does he usually receive friends in his home?  
Are his friends his spouse's friends?  
Does his spouse accompany him when he visits?  
Is he visiting friends less frequently because of his  
drinking?  
Is he active in any civic organization?  
Has drinking affected this activity?  
Any contacts with the police?  
Has he ever been in a traffic accident?  
Any trouble with neighbors?

### **Drinking and the Job**

Late to work because of drinking?  
Ever miss work because of drinking?  
Does his supervisor know about his drinking?  
Did he ever discuss it with him?  
Is his job in jeopardy because of his drinking?  
Suppose he is fired, what would he do then?

### **The Drinker's Family**

How many children does he have? What ages?  
Do they go to school? Do they work?  
Do they know that father (mother) is drinking?  
Do the children drink alcoholic beverages? socially  
at home? at home with parents during meals?  
occasionally at home? alone? with their friends?

### **Self-Evaluation**

Does he think he is an alcoholic?  
Who is an alcoholic?  
How would he define alcoholism?  
Do his friends and family understand him?  
Is he rejected? jealous?



Is he more jealous now?  
Does he have a hobby? Does it interest him?  
How does he spend his free time?

#### The Drinkers and AA

Did he hear, does he know about AA?  
Did he visit AA?  
How often did he go?  
Did AA help him?  
What is his opinion of AA?

#### Church

Does he go to church?  
Did he speak to his church father or pastor about his drinking?  
Did he help him?

#### The Physician

Does his family physician know about his drinking?  
Did he help him?  
What did he do for the patient?

#### General Health

How does he feel now?  
Does he have any complaints about his health?  
How is his appetite?  
How many meals a day does he eat?

Is there any change in his weight?  
Did he ever have bad delirium tremens (DT's)?  
How much does he smoke? Cigarettes, pipe, cigars?  
Does he take sleeping pills, tranquilizers, bennies, or goof balls?  
Any trouble urinating?  
How does he sleep?  
Has his sex life changed during the last few years?  
Does alcohol make it easier (or more difficult) to get an erection?  
Is his spouse less willing to engage in sexual relations if he has liquor on his breath?  
Does he have palpitations of the heart?  
Would he consider himself nervous?  
Does drinking make him more nervous or less nervous?  
What medicines is he taking?  
Did any physician tell him that he should take alcohol for medicinal purposes?  
Is his handwriting more shaky now than it used to be?

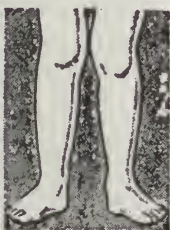
#### Summary

The examiner reviews the answers and summarizes the significant ones. It is hoped that this form will aid physicians in handling alcoholics, as well as serve as a reference sheet in directing the alcoholic for proper treatment.

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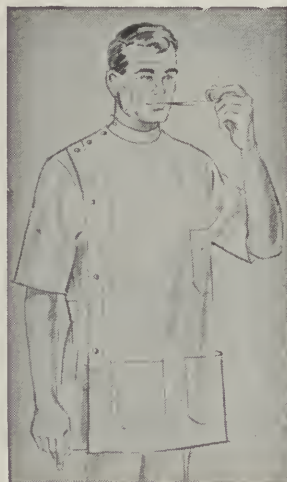


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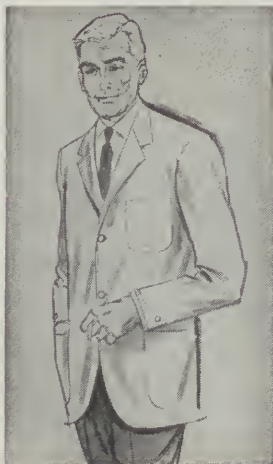


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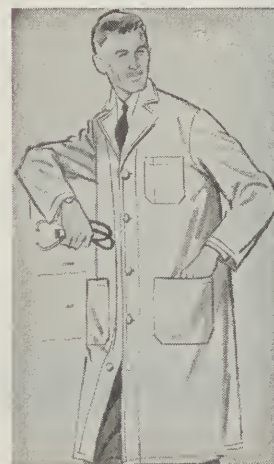
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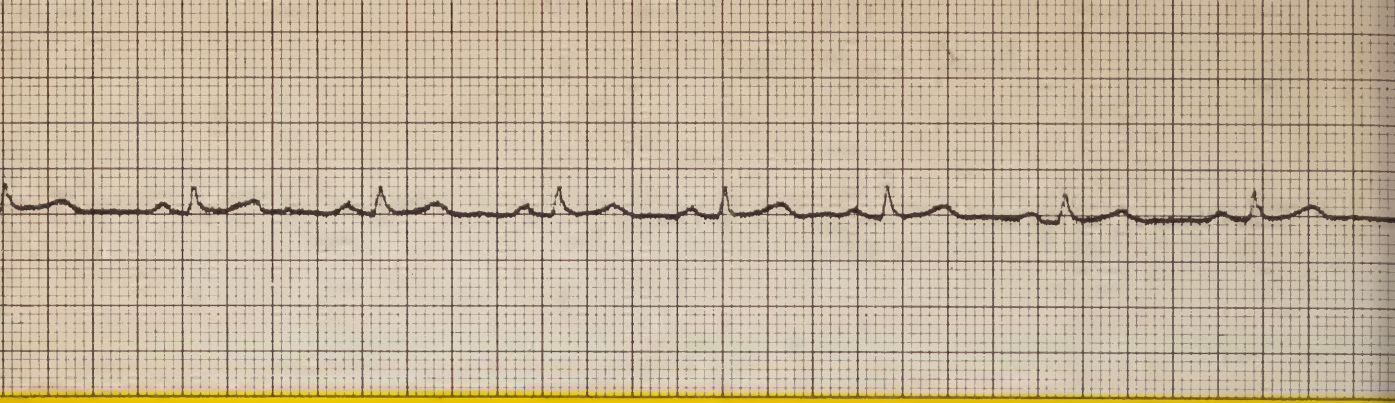
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or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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# IF MORE MEN CRIED

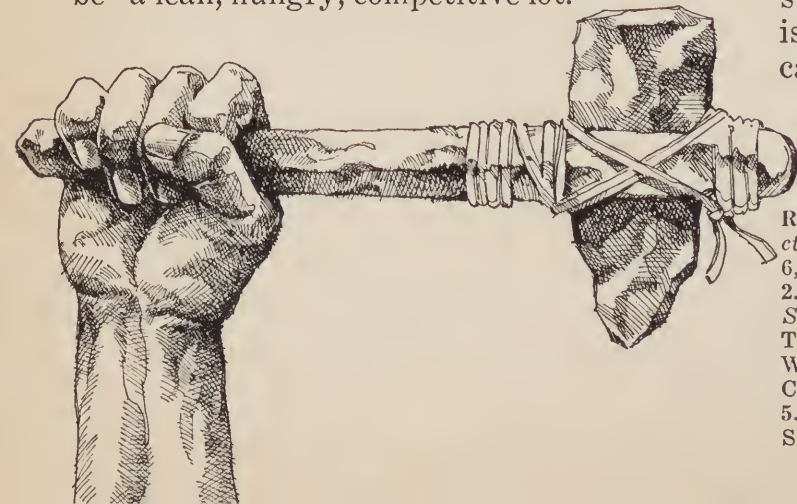


At least seventy-five out of one hundred adults with duodenal ulcers are men.<sup>1</sup>

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."<sup>2</sup>

**Hypersecretion—an atavistic response.** Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."<sup>2</sup>

**By chance? A lean, hungry lot.** Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."<sup>3</sup>



**Big boys don't cry.** If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total



their genes and what they are taught. Schottstae observes that when mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.<sup>4</sup> Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age

**Take away stress, you can take away symptoms**

There is no question that stress plays a role in the etiology of duodenal ulcers. Alvarez<sup>5</sup> observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

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References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M., et al. (eds.): *Harrison's Principles of Internal Medicine*, 6, New York, McGraw-Hill Book Company, 1970, p. 14. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff: Stress and Disease*, ed. 2, Springfield, Ill., Charles C. Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstae, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 1. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.



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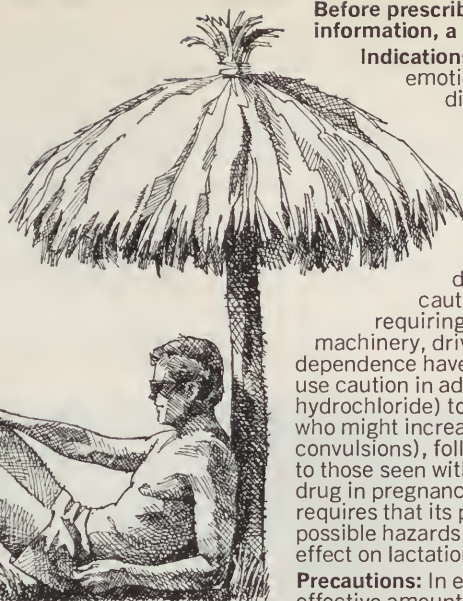
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**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, over-sedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



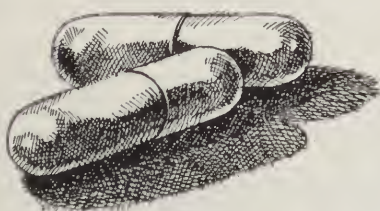
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**MARCH 18-20, 1971**

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24th National Conference on Rural Health: Atlanta Marriott Motor Hotel, Atlanta, Georgia. Contact: American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

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3rd International Congress of Psychosomatic Medicine in Obstetrics and Gynecology: London, England. Contact: Kurt Fleischman and Associates, Chesham House, 136 Regent St., London W1, England.

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**COUNCIL ON MEDICAL SERVICE, DIVISION OF MEDICAL PRACTICE, AMERICAN MEDICAL ASSOCIATION**

Fifth National Congress on the Socioeconomics of Health Care—Current Issues in Medical Care Delivery: Caesars Palace, Las Vegas, Nevada. Advance registration is requested; there is no registration fee. Write: American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610, Attention: Secretary, Council on Medical Service.

**APRIL 3-4, 1971**

**SOUTHEASTERN DERMATOLOGICAL ASSOCIATION**

Meeting: Augusta, Georgia. Robert Kierland, MD, will be guest clinician and Richard Reed, MD, will be dermatopathologist. All sessions will be moderated by Wiley M. Sams, MD, of Augusta, Georgia. Contact: J. Graham Smith, Jr., MD, Medical College of Georgia, Augusta, Georgia 30902.

**APRIL 5-7, 1971**

**AMERICAN COLLEGE OF SURGEONS**

North American Sectional Meeting: Queen Elizabeth Hotel, Montreal, Canada. Contact: American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

**APRIL 5-7, 1971**

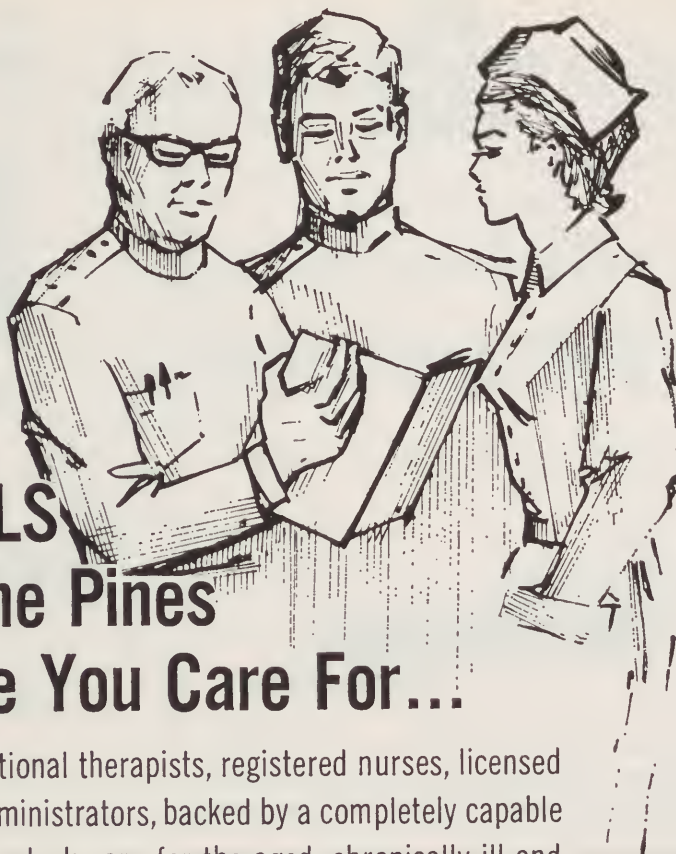
**ROYAL SOCIETY OF MEDICINE**

Conference on Medical Care: London, England. Contact: J. Curtis Herge, Royal Society of Medicine Foundation, 20 Broad St., New York, N.Y. 10005.

*(Continued on page 14)*



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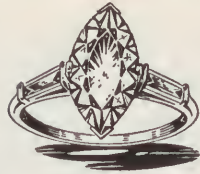
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# executive director's newsletter

March, 1971

## COMPONENT SOCIETY VISITS

The Executive Director has almost completed visits to component medical societies throughout the state. Wicomico, Frederick, Talbot, Cecil, and Howard counties were visited during January and February.

Visits are being arranged for the statewide specialty societies, and the Maryland Ear, Nose and Throat Society is the first on the list. Others scheduled include the Maryland Industrial Medical Association, the Maryland Psychiatry Society, and the Maryland Ob/Gyn group.

## COMPONENT VISITS WITH STATE LEGISLATORS

They say that imitation is the highest form of flattery. So, we can only comment that most other professional groups are following the Faculty's lead in meeting with their state General Assembly delegations to offer assistance in the field of health legislation.

Most components throughout the state have already discussed the Faculty's legislative program for 1971 with their local delegations.

## ASSEMBLYMAN PUBLISHED

Be on the lookout for the second issue of The Assemblyman which will provide an up-to-date look at legislative issues, together with a listing of bills related to health matters.

## DATES TO NOTE

Faculty-sponsored activity during the next few months includes the following noteworthy sessions:

Wednesday, March 31 -- Seminar for Medical Emergency Room Services, all day, at St. Joseph's Hospital

Wednesday through Friday, May 12-14 -- Faculty's Annual Meeting, Civic Center, Baltimore

Sunday through Sunday, May 16-23 -- all-inclusive tour direct from Friendship Airport to London, England

Saturday, September 11 -- Semiannual House of Delegates meeting, Faculty building, Baltimore

Wednesday through Sunday, September 15-19 -- Semiannual Scientific Sessions, El Conquistador Hotel, San Juan, Puerto Rico



COMMISSION  
ON  
MEDICAL  
DISCIPLINE

Initial information from the Commission on Medical Discipline reveals that for the period July 1, 1969 through December 31, 1970, a total of 26 cases were referred for disciplinary action.

Three individuals voluntarily surrendered their licenses; seven physicians were reprimanded; one license was revoked, with stay of revocation with the physician placed on indefinite probation; two physicians were placed on indefinite probation only; and four cases were closed out (one by death, one by dismissal of the case in court for lack of evidence, and two for lack of evidence).

Nine cases were still pending with the commission at the close of this period.

OFFICE-BASED  
AMBULATORY  
CARE  
SURVEY

A National Ambulatory Care Survey is being conducted by the National Center for Health Statistics. The survey will eventually be conducted on a national sample basis among physicians providing ambulatory care in office practice.

A field test of the survey is now underway, and about 750 physicians, a few of which may be in Maryland, are participating. Cooperation in the entire sample group is essential. If any Maryland physicians are contacted in this connection, they are urged to lend their support.

Further information may be obtained from the Faculty office.

JCAH  
STANDARDS

Each state medical society has received one copy of the new Standards for Accreditation of Hospitals. No additional copies will be available until after April 1, 1971.

This copy is available for review in the Faculty office, but may not be borrowed because of the intense interest in this new publication.

  
Executive Director



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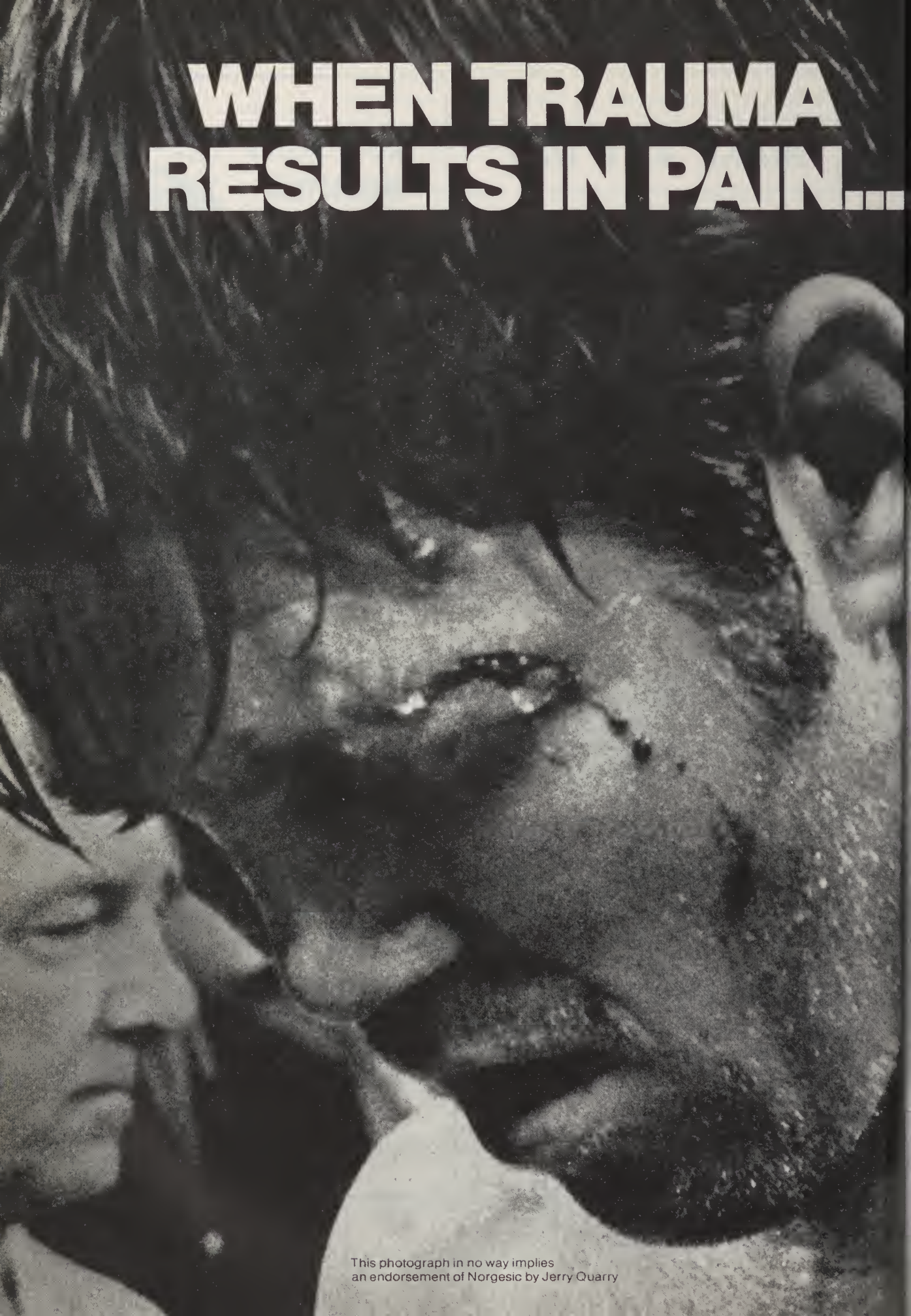
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provides predictable relief—overall satisfactory response in approximately 80% of patients

the versatile analgesic

## NORGESIC<sup>®</sup>

(orphenadrine citrate, 25 mg.; aspirin, 225 mg.; phenacetin, 160 mg.; caffeine, 30 mg.)

**Contraindications:** Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine.

Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon<sup>®</sup>).

**Warnings:** USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

**Precautions:** It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

**Adverse Reactions:** Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.

**Dosage and Administration:** Adults—1 to 2 tablets 3 to 4 times daily.

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## Doctors Take Note . . .

*(Continued from page 6)*

### **APRIL 7, 1971**

#### **WASHINGTON HEART ASSOCIATION/HEART ASSOCIATION OF NORTHERN VIRGINIA, INC.**

14th Annual Joint Cardiac Symposium: 9 AM to 3:30 PM, Persian Room, Marriott Twin Bridges Motor Hotel, U. S. #1, Arlington, Virginia. Contact: Heart Association of Northern Virginia, 609 N. Edgewood St., Arlington, Va. 22201.

### **APRIL 7-9, 1971**

#### **AMERICAN HEART ASSOCIATION**

Three Days of Cardiology for Nurses—Prevention and Health Maintenance in CVD Nursing: Holiday Inn Rivermont, Memphis, Tennessee. Write: Heart Association of Maryland, 415 N. Charles St., Balto., Md. 21201.

### **APRIL 12-16, 1971**

#### **THE JOHNS HOPKINS HOSPITAL**

Postgraduate Course—Growth, Pediatric Endocrinology and Metabolism: The Johns Hopkins University School of Medicine, Baltimore, Md. Contact: Robert M. Blizzard, MD, Eudowood Professor of Pediatrics, The Johns Hopkins Hospital, Baltimore, Md. 21205.

### **APRIL 13-15, 1971**

#### **MC GRAW-HILL PUBLICATIONS COMPANY**

3rd National Conference and Exposition on Electronics in Medicine: Sheraton-Boston Hotel, Boston, Massachusetts. The meeting will combine topical addresses by leading physicians, engineers, and government officials with a schedule of workshops and seminars in which all conference registrants may participate. For information on exhibit arrangements, write: Jerry Brown, National Expositions Company, 14 West 40th Street, New York, N.Y. 10018.

### **APRIL 16-18, 1971**

#### **AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE/DEPARTMENT OF HEALTH, EDUCATION AND WELFARE**

Regional Conference on the Workings of Foundations for Medical Care: Rochester, New York. The meeting will contain a peer-review workshop, and will also deal with administration and basic Foundation functions. Registration fee is \$150 per association. For additional information, write: MATS, P. O. Box 230, Stockton, California 95201.

### **APRIL 19-21, 1971**

#### **AMERICAN DIABETES ASSOCIATION/UNIVERSITY OF CALIFORNIA, SAN FRANCISCO**

Third Allied Health Postgraduate Course in Diabetes: San Francisco, California. The course will include workshops, panel discussions, and morning and afternoon sessions. Fee: \$50 for members of the association; \$65 for nonmembers. Write: American Diabetes Association, Inc., 18 East 48th St., New York, N. Y. 10017.

### **APRIL 19-21, 1971**

#### **AMERICAN ACADEMY OF PEDIATRICS**

Annual Spring Session: Chase-Park Plaza Hotel, St. Louis, Missouri. The session will cover subjects such as the pediatrician's role in ecology, intensive care units for high-risk infants, concepts and relationship to the community, and pediatric evaluation and management of learning the behavioral disorders. For information, write: American Academy of Pediatrics, Department of Public Information, 1801 Hinman Avenue, Evanston, Illinois 60204.



## Baltimore County Medical Society

The annual meeting of the Baltimore County Medical Association was held on Wednesday, December 16, 1970, at the Tail of the Fox restaurant. The meeting was called to order by the president, Wilmer K. Gallagher, Jr., MD. Dr. Gallagher welcomed the members and their spouses and introduced three new members—John Hebb, MD, Osne Hume, MD, and Alfred Iwantsch, MD.

The following officers were elected to serve for 1971: John M. Krager, MD, president; Herbert J. Levickas, MD, vice-president; Baltasar B. Velez, MD, secretary; and James D. Drinkard, MD, treasurer.

The following physicians were elected to serve as delegates to the House of Delegates: D. Delmas Caples, MD, Melvin B. Davis, MD, E. Gordon Grau, MD, Edward L. Krieg, MD, William McGrath, MD, Samuel Scalia, MD, Margaret Sherrard, MD, and S. J. Venable, Jr., MD. William Wade, MD, Roger Windsor, MD, John Hyle, MD, William Andersen, MD, Theodore Toulon, MD, Barbara Solomon, MD, and Frank Kasik, MD, were appointed as alternates.

After the election of officers, Dr. Gallagher thanked the Board of Governors and all committees for their cooperation during the past year. At the conclusion of his report to the association, Dr. Gallagher was given a standing ovation for a job well done.

Dr. Gallagher then presented the Cane and Gavel to the new president, John Krager, MD, who pledged his support to the society for the coming year.

Dr. Krager presented the past-president's plaque to Dr. Gallagher in recognition of his outstanding leadership during 1970.

The new location of the Baltimore County Medical Association office is 10 Gerard Avenue, Suite 108, Lutherville, Timonium, Maryland 21093.

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Chairman, Public Relations Committee

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**WEDNESDAY, MARCH 31, 1971  
At St. Joseph Hospital, Towson, Maryland**

**PRACTICAL EMERGENCY DEPARTMENT SERVICE  
A Symposium**

**9:30 AM—11:15 AM**

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EQUIPMENT: THE GOOD AND THE DANGEROUS

**Captain Harold Evans**, Baltimore County Fire Department

EMERGENCY ATTENDANTS DO NEED MORE TRAINING THAN BARBER SURGEONS!

**Perry Stearns, MD**, Assistant Commissioner, Community Health Services, Department of Health and Mental Hygiene of Maryland

CERTIFICATION: HOW TO DO IT EFFECTIVELY

**James D. Carr, MD**, Assistant Commissioner for Local Health Services, Baltimore City Health Department

HOW TO COORDINATE EMERGENCY SERVICES

**Battalion Chief Martin C. McMahon**, Baltimore City Fire Department

SPECIAL RIDES FOR SPECIAL PATIENTS

**R Adams Cowley, MD**, Program Director, Center for the Study of Trauma, University of Maryland School of Medicine

**11:15 AM—11:30 AM**

**INTERMISSION**

Coffee and soft drinks will be served

**11:30 AM—1:00 PM**

**CAN YOU FUNCTION WITH JUST ANY STAFF?**

TEACHING ALSO HELPS PATIENTS

**Joseph Berman, MD, MPH**, Chief, Community Medicine, Sinai Hospital of Baltimore

THE PRACTICALITY OF A FULLY PRIVATE STAFF

**Emidio A. Bianco, MD**, Medical Director, St. Agnes Hospital  
Emergency Room Physicians, Inc.—St. Agnes Hospital, Baltimore

**1:00 PM—2:00 PM**

**LUNCH**

Courtesy of **St. Joseph Hospital**, Towson, Maryland

**2:00 PM—3:00 PM**

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The Sheppard and Enoch Pratt Hospital, Towson, Maryland

**Robert W. Gibson, MD**, Medical Director

**Kent E. Robinson, MD**, Director, Outpatient Services

**Arthur N. Hildreth, MD**, Staff Psychiatrist

**3:00 PM—3:15 PM**

**INTERMISSION**

Coffee and soft drinks will be served



3:15 PM—4:00 PM

**CRYPTIC CRISES**

Leon J. Taubenhau, MD, Chief of Community Medicine, Beekman-Downtown Hospital, New York city

4:00 PM—4:45 PM

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This program is acceptable for six elective credit hours by the American Academy of General Practice

**Ad Hoc Planning Committee for Symposium**

John B. De Hoff, MD, Chairman, George H. Greenstein, MD, Sidney D. Kreider, MD, Eugene J. Riley, MD

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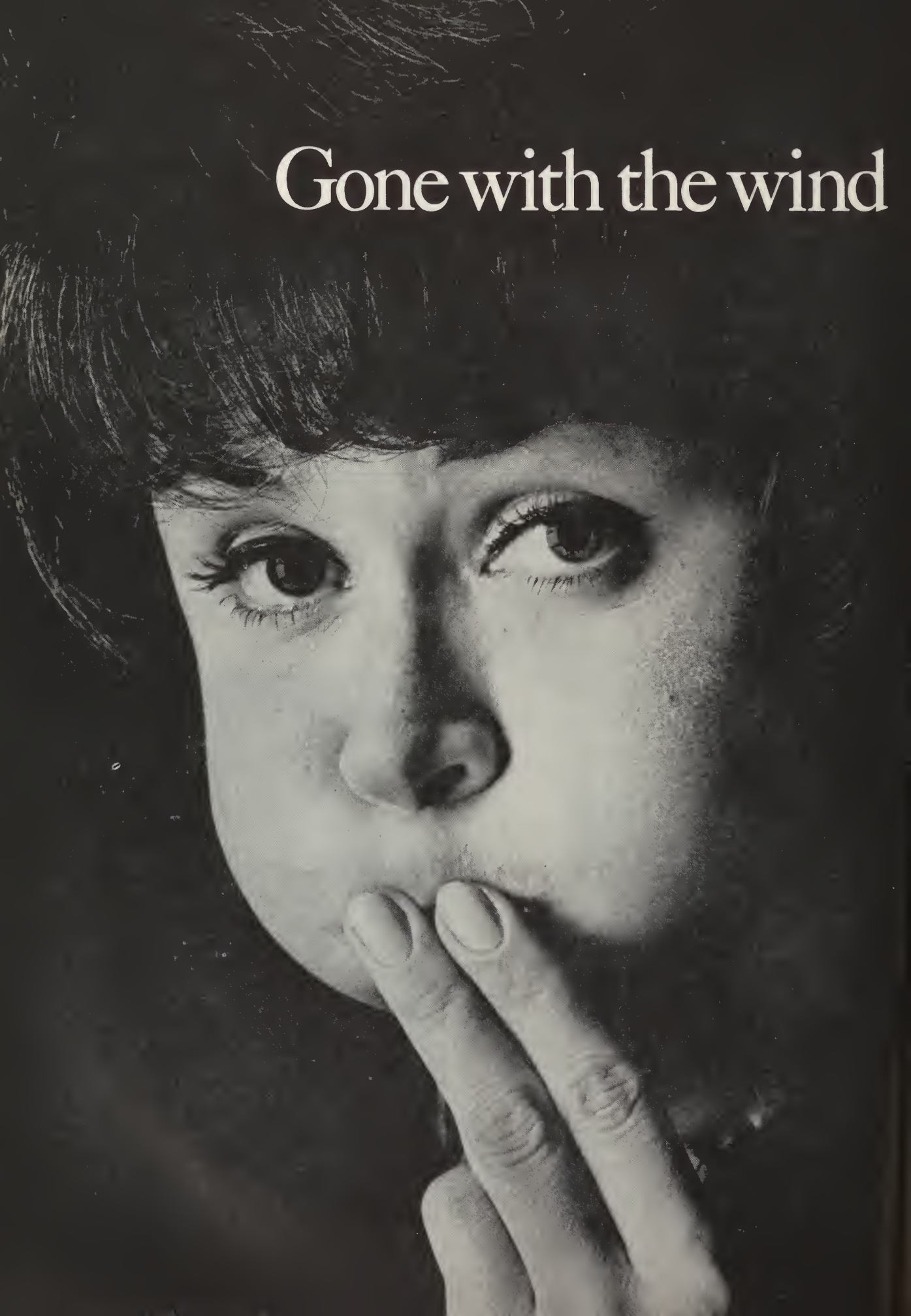
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\*Slinger, A.: Med. Times 94:150 (Feb.) 1966.

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**Tablets:** simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

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**one dose does both: frees captured gas...neutralizes free acid**



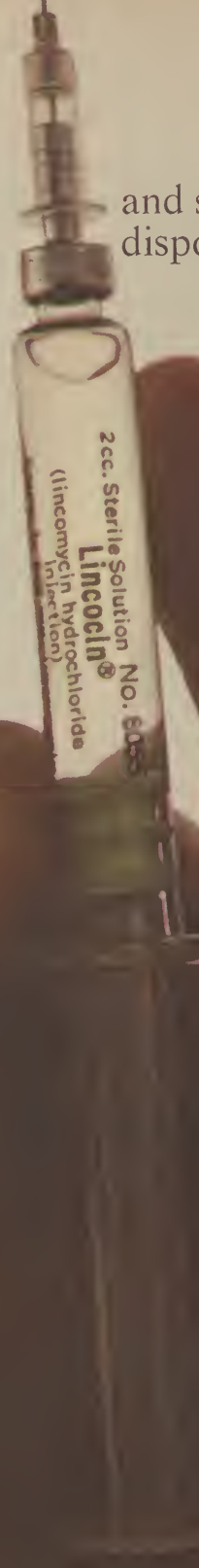
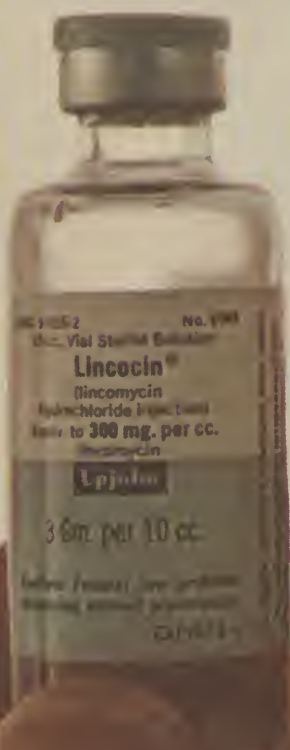
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A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



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Each tablet contains:

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# Multivitamins with pyridoxine can impair levodopa therapy

**Your patient with Parkinson's disease and syndrome may be taking a nonprescription multivitamin containing B<sub>6</sub>.**

Vitamin B<sub>6</sub> reportedly reduces the benefits of levodopa, and may lead to discontinuance of therapy because of apparent ineffectiveness.



**Larobec provides needed nutritional support without pyridoxine (vitamin B<sub>6</sub>)...and helps ensure that your levodopa therapy is not impaired by self-medication with a pyridoxine-containing multivitamin preparation.**

## Complete Prescribing Information:

Each Larobec tablet contains:

Thiamine mononitrate (vitamin B <sub>1</sub> )	15 mg
Riboflavin (vitamin B <sub>2</sub> )	15 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin (vitamin B <sub>12</sub> )	5 mcg
Folic acid	0.5 mg
Ascorbic acid (vitamin C)	500 mg

**Description:** For prophylactic or therapeutic nutritional supplementation concomitant with levodopa therapy in patients with Parkinson's disease and syndrome, Larobec provides high potency dosages of the major B-complex vitamins, without pyridoxine (vitamin B<sub>6</sub>) which has been reported<sup>1,2</sup> to reduce the clinical benefits of levodopa therapy. B-complex vitamins are essential in the anabolism of carbohydrate and protein and in hematopoiesis. Larobec also contains therapeutic quantities of ascorbic acid, a substance involved in intracellular reactions such as tissue repair and collagen formation.

**Indications:** Larobec is indicated for supportive nutritional supplementation when a water-soluble vitamin formula (without pyridoxine) is required prophylactically or therapeutically in patients under treatment with levodopa.

**Warning:** Administration of vitamin B<sub>6</sub> may be required if signs of pyridoxine deficiency develop. Larobec is not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B<sub>12</sub>.

**Dosage and Administration:** One or two tablets daily, as indicated by clinical need.

**How Supplied:** Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.

## References:

1. Duvoisin, R. C., et al.: *Trans. Amer. Neurol. Assoc.*, 94:81, 1969.
2. Cotzias, G. C.: *J.A.M.A.*, 210:1255, 1969.



The "incomplete"  
B-complex

**Larobec**<sup>T.M.</sup>  
TABLETS

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President Nixon was pronounced in "excellent health" with a "young man's blood pressure" after his annual physical checkup.

Air Force Brig. Gen. Walter Tkach, MD, the President's physician, said that all the tests given the nation's chief executive at the Bethesda (Md.) Naval Medical Center were within normal limits. The examination team of five physicians including himself, Tkach said, found Nixon's blood pressure to be 118/82 compared to last year's reading of 120/80. He described it as a "young man's blood pressure, ideal" for the President who was only ten days short of his 58th birthday.

Tkach's only recommendation for Nixon was that he take more time for exercise and recreation, preferably in California or Florida. The President partly heeded the advice, going to California shortly thereafter for a "working vacation".

\* \* \*

**President Nixon has promised that every effort will be made to keep bureaucracy at a minimum in connection with his new over-all national health program even before he disclosed its details.**

"... We do not want the doctors and those in the medical profession to be smothered under a whole, huge bureaucracy and under a great pile of government forms," he said in a speech at the 20th annual meeting of the American College of Cardiology prior to his acceptance of the college's 1971 Humanitarian Award.

Nixon said that he recognized that there is no program for medical care that would be good for the patient unless it is supported by physicians and has the cooperation of the medical profession.

"So we want your advice, we want your cooperation, we want to work together with you in



## THE MONTH IN WASHINGTON

developing a program that will do what is needed to be done and do the best for our patients, your patients, but also that will enable you to meet your responsibilities as unhampered as is possible by federal bureaucracy, red tape, and the like," he said.

"That is our objective and I will simply say . . . that as this debate goes on through the year that I know that we will have your cooperation.

"I know the dedicated men and women that are in this profession. And I can assure you that we will listen. We want your advice because, as I said in the state of the union message, we have one great goal."

In the state of the union message, the President said:

"As a fourth great goal, I will offer a far-reaching set of proposals for improving America's health care and making it available more fairly to more people.

"I will propose:

"A program to insure that no American family will be prevented from obtaining basic medical care by inability to pay.

"A major increase in and re-direction of aid to medical

schools, to greatly increase the number of doctors and other health personnel.

"Incentives to improve the delivery of health services, to get more medical care resources into those areas that have not been adequately served, to make greater use of medical assistants, and to slow the alarming rise in the costs of medical care.

"New programs to encourage better preventive medicine, by attacking the causes of disease and injury, and by providing incentives to doctors to keep people well rather than just to treat them when they are sick.

"I will also ask for an appropriation of an extra \$100 million to launch an intensive campaign to find a cure for cancer, and I will ask later for whatever additional funds can effectively be used. The time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dread disease. Let us make a total national commitment to achieve this goal.

"America has long been the wealthiest nation in the world. Now it is time we became the healthiest nation in the world."

In his budget message, Nixon said he later would send a message to Congress "that will set out a national health strategy for the seventies and propose significant changes in the federal role in the nation's system of health care."

"This strategy will seek to expand preventive care, to train more doctors and other health personnel, to achieve greater equity and efficiency in the delivery of health services," he said. "It will include a new health insurance program for all low-income families with children."

\* \* \*

**The Nixon Administration asked Congress for tighter government control over any peer-**



**review setup for medicare and medicaid than would be provided by the so-called Bennett amendment approved by the Senate last year.**

Elliot L. Richardson, Secretary of Health, Education and Welfare, told the House Ways and Means Committee:

"We agree with the objective of assuring an expanded role for the medical profession in peer-review activities and recognize the need for improvement of utilization review procedures. However, certain modifications in the senate provisions would be desirable. For example, we do not think that the secretary of HEW should be required to use medical-society-sponsored groups in situations where there may be a highly qualified review organization in the area that has already demonstrated its ability to perform well. We also favor giving the secretary some greater flexibility to permit, through regulations, variations in the structure and patterns of operation of peer-review groups."

Richardson was testifying on H.R. 1 of the 92nd Congress. The social security measure includes provisions for peer review and other changes in medicare and medicaid. Both chambers of Congress passed such legislation last year but the senate added so many amendments to the house-passed bill that congressional leaders decided it would be futile for a house-senate conference committee to try to reconcile the differences. The house committee made the legislation the first order of business this year and the legislation was expected to get through Congress within a few months.

Richardson again asked for authority to use health maintenance organizations (HMO's), or prepaid group practice, for the government programs. He also renewed a request for authority to limit physicians' fees and other provider costs under medicare. Both provisions were

approved in varying forms by the house and senate last year and, consequently, it appeared likely that some versions of the provisions, along with peer review, would become law in the first half of this year.

Richardson said HMO's would mean progress toward "our goal of emphasizing preventive medical care." He added:

"We believe that HMO's can help solve many of the problems facing the health-care system today—the uncontrolled rise in health-care costs, overutilization, particularly of high cost services, disorganization, improper allocation of resources, inadequate emphasis on preventive care, and inefficient use of available health manpower. In the long run, the encouragement of HMO's may be the most important step we can take to stimulate the restructuring of the health delivery system. We hope that health maintenance organizations, and their use by beneficiaries, will expand greatly in the future, and we believe that there can be significant long-run savings in program costs due to the HMO option."

Concerning the proposed limitation on increases in physicians' fees, Richardson said:

"Another major change relating to medicare reimbursement that is recommended by the Administration is one which would limit medicare's recognition of prevailing charge increases to rates that economic data indicate would be fair to all concerned. We believe that if recognition of fee increases is tied to appropriate economic indexes, this will help to assure that the recognition of such increases is appropriately related to developments in other pertinent sectors of the economy."

Administration sources said HEW later would seek authority for other economy measures to cut medicare costs. These included:

—Reduction of the 60-day

period of hospitalization during which beneficiaries pay relatively little.

—Increase of the annual \$50 deductible a beneficiary must pay toward his physician's fees under Part B.

—Tightening up on payments to nursing homes for custodial care.

The American Nursing Home Association already has withdrawn official support of the medicare program for extended care and has urged its more than 7,000 nursing home members to reassess their participation.

"The tragic aspect of the medicare program for extended care is that the Social Security Administration led America's senior citizens to believe that if their physicians thought it necessary, they were entitled to 100 days of custodial care at government expense," David R. Mosher, ANHA president, said. "Subsequent rules and regulations issued by SSA have virtually ruled this out."

\* \* \*

**A National Commission on VD (venereal disease) has been formed to alert the public to the dangers of gonorrhea and syphilis which now afflict an estimated more than 2 million Americans.**

Dr. Bruce Webster of New York city, president of the American Social Health Association, was named chairman of the commission which was created by the Department of Health, Education and Welfare to consider the problems of syphilis and gonorrhea from a national standpoint, study ways of bringing public health and private medicine into closer working relationship, and make recommendations for bringing the two diseases under control.

The commission, in seeking to define a national strategy for the better control of the venereal diseases, will submit its recom-



mentations to the various professional groups represented on the commission, as well as to HEW.

Dr. Roger O. Egeberg, HEW assistant secretary for Health and Scientific Affairs, designated the Center for Disease Control in Atlanta to provide staff support for the commission.

"In 1968, a national incidence survey conducted by the American Social Health Association for the Public Health Service found that although private physicians treat about 80% of the venereal disease cases, they report only one in nine to public health officials," Dr. Webster said. "We believe that this commission will serve as the long-needed link between public health and private medicine."

Estimating about 2 million cases of gonorrhea and 75,000 cases of infectious syphilis in the United States last year, the

ASHA, which has waged continuing campaigns against the diseases since World War I, said VD had reached pandemic proportions for the third time. The two previous times were at the close of the two world wars. Dr. Jesse Steinfeld, Surgeon General of the U.S. Public Health Service, said gonorrhea has gotten "out of control and must be considered a national epidemic of major proportions." Dr. James McKenzie-Pollack, ASHA medical director, said that "for the first time in the penicillin era, we are seeing serious clinical complications of gonorrhea in the female."

Even with only a small fraction of VD cases reported, gonorrhea ranks first and syphilis fourth among reportable diseases in the United States.

Early in 1969, ASHA was asked by the American Medical Association, National Medical

Association, and American Osteopathic Association to convene 23 health and medical organizations for the purpose of discussing a national VD prevention and control policy. Out of the meeting which followed came the plan for a national commission.

The following professional organizations are represented on the commission:

American Academy of Dermatology, American Academy of General Practice, American Academy of Neurology, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, AMA, ASHA, American Public Health Association, AOA, American Urological Association, American Venereal Disease Association, Association of American Medical Colleges, and NMA.

\* \* \*

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**SURGERY AND BIOLOGY OF WOUND REPAIR**, Earle E. Peacock, Jr., MD, and Walton Van Winkle, Jr., MD; The W. B. Saunders Company, Philadelphia, Pennsylvania, 1970.

This book attempts to demonstrate to basic scientists that there is a real discipline known as human biology and that wound healing is an area of investigation in which the best of scientific thought and practice can be truly used with gratifying results. As in most scientific disciplines, there is a gap between brilliant research accomplishments and practical clinical applications.

It is also an attempt to let those interested understand why and how certain therapeutic regimens work and thus advance the ability to fully use some of the lessons that have been learned by trial and error.

It accomplishes both of these purposes, as well as additional ones.

**CRC HANDBOOK OF BIOCHEMISTRY**, 2nd edition. Herbert A. Sober, PhD; The Chemical Rubber Company, Cleveland, Ohio, 1970.

The second edition of this publication is about 600 pages larger than the previous edition. All tables have been extensively revised, up-dated, and expanded to include and accommodate new data developed since 1968. The index has also been enlarged.

The book's major emphasis is on today's principal research frontiers and, as a result, certain areas of important biochemical interest are relatively neglected.

Although principally useful as a resource material, this book will also be helpful to all concerned with the areas that it covers.



**UROLOGICAL SURGERY**, Austin Ingram Dodson, Jr., MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This book has as two of its contributors Albert E. Goldstein, MD, a former Faculty President, and his son, Robert B. Goldstein, MD.

The revised edition of this publication serves to keep those involved in urological surgery informed of the advances that are constantly occurring in their field.

New chapters in this volume include Radiation Therapy and Preoperative and Postoperative Care.

**CANCER, DIAGNOSIS, TREATMENT AND PROGNOSIS**, Lauren V. Ackerman, MD, and Juan A. del Regato, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This is the fourth edition of this publication. It is designed to bring general information to the student, to the general practitioner, and to those specialists involved in the diagnosis and treatment of malignant tumors.

The intention of the authors is to provide an integrated view of all aspects of this problem, such as its clinical evolution, the differential diagnosis, and histopathology, incidence, and prognosis. The authors have succeeded admirably in their goal.

It is believed that the last paragraph contained in the foreword to this book is worth repeating:

"Thousands of patients everywhere are depending on the judgment, knowledge, and skill of their various physicians. Although some forms of cancer remain incurable, there is no room for temporizing guesswork, amateurish approaches, or defeatist attitudes. Success depends entirely on intelligent understanding, skillful treatment and a hopeful, compassionate attitude."

**SELECTED BIBLIOGRAPHY OF ORTHOPAEDIC SURGERY**, 2nd edition. Edited by the American Academy of Orthopaedic Surgeons. The C. V. Mosby Company, St. Louis, Missouri, 1970.

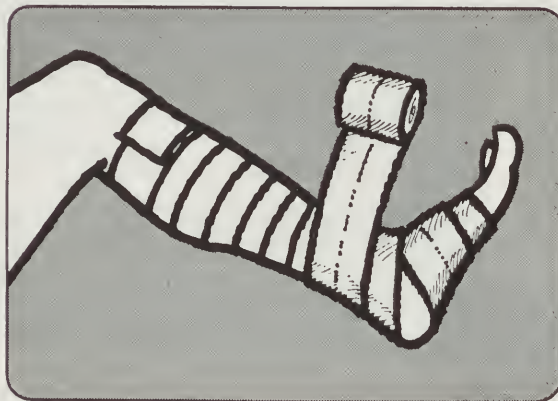
This selected bibliography was published to make it easier for those interested in orthopaedic surgery to select references pertaining to specific subjects. Over 6,000 new references were reviewed before the material was compiled in this book. Older references were removed when newer ones seemed either more timely or more complete.

All in all, it is an excellent publication that should be unquestionably added to all libraries that have a use for it.

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MRS. ROBERT W. GARIS, EDITOR

## woman's auxiliary

### Doctors' Day

In 1935, the Woman's Auxiliary of the Southern Medical Association adopted a project whereby every southern state set aside March 30 to honor members of the medical profession, both living and dead. This date was chosen to honor Dr. Crawford W. Long, the famous Georgian physician who first used ether as an anesthetic agent in a surgical operation in 1842.

Our adoption of the red carnation as a symbol of Doctors' Day was made official in 1949. As the official symbol, the flower pays tribute to the members of the medical profession.

The State Auxiliary of Maryland honors our physicians in many ways. Governor Mandel annually proclaims March 30 as Doctors' Day in Maryland. Some of the county auxiliaries have gotten similar proclamations from the mayors of their cities. Throughout the state, the auxiliaries are busy with plans to give the public an opportunity to say "thank you" to our physicians.

The Carroll County Auxiliary will place a red carnation on the dinner tray of every patient in its hospital, along with an explanation of Doctors' Day. WTTR will present a taped interview between Mr. Paul Smith and two of the oldest physicians in Carroll County. They will discuss medical treatment many years ago and now, stressing the differences.

The Enoch Pratt Free Library has loaned the Baltimore City Medical Auxiliary window space for a display between March 23 and April 19—be sure to look for it. The auxiliary also makes a contribution to the American Medical Association Education and Research Foundation to be divided between the University of Maryland and The Johns Hopkins hospitals.

The Washington County Auxiliary plans a Spanish

dinner for their physicians, complete with Spanish costumes and music. This should be a fun evening.

The Wicomico Auxiliary will place a silver bowl of red carnations and a poster explaining Doctors' Day in the lobby of their hospital.

Many counties will give progressive dinners. Prince George's County Auxiliary plans a luncheon at the Prince George's General Hospital. The county auxiliary members will pin a red carnation on each of the physicians in honor of the day.

Each year, we try to educate the public on this day and spotlight the many fine surgeons and physicians in Maryland. Hopefully, we will gain support for future advancements in the medical field. As state chairman for the auxiliary, I hope that each of you in your home county will be so honored by your component auxiliary.

**Mrs. Frank E. Poole**  
Chairman, Doctors' Day  
State Auxiliary

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**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of SerAp-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient. **Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

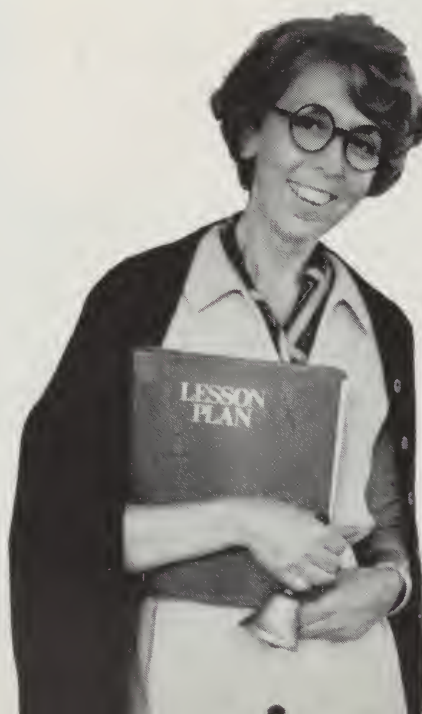
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# C I B A



# MEDICAL NEWS

**John E. Hoopes, MD**, a fellow of the American College of Surgeons, has been named Professor and Director of Plastic Surgery at The Johns Hopkins University School of Medicine, and Plastic Surgeon In Charge at The Johns Hopkins Hospital.

Dr. Hoopes is former Associate Professor of Surgery at Washington University School of Medicine in St. Louis, Missouri.

\* \* \*

**David Rosenthal, PhD**, recently received the Ninth Annual Stanley R. Dean Research Award for his studies of the role of heredity and environment in schizophrenia.

Dr. Rosenthal is Chief of the National Institute of Mental Health's Laboratory of Psychology in Bethesda. He also served as Assistant Professor of Medical Psychology at The Johns Hopkins University School of Medicine for four years.

\* \* \*

The Maryland Association for Mental Health recently held its annual legislative dinner meeting in Annapolis. Serving on the Legislative Committee of the MAMH to determine the association's position on legislation affecting the mentally ill are **Gary Fleming, MD**, of Cumberland, and **Frederick T. Sparrow, MD**, of Baltimore.

\* \* \*

**Laurence R. Gallager, MD**, of Columbia, has been appointed Associate Director of Medical Education at St. Agnes Hospital in Baltimore. The announcement was made by Emidio A. Bianco, MD, the hospital's medical director and director of medical education.

In his new capacity, Dr. Gallager is responsible for planning, developing, and organizing methods of recruiting medical graduates for the hospital's intern and medical education program.

Dr. Gallager, whose father,

Wilmer K. Gallager, Sr., MD, and brother, Wilmer K. Gallager, Jr., MD, are also members of the St. Agnes staff, received his MD degree from the University of Maryland School of Medicine.

After completing his final year of residency at St. Agnes Hospital as Executive Chief Resident in Medicine, Dr. Gallager lived more than a year in West Pakistan doing clinical research in febrile illnesses.



**Dr. Gallager**

\* \* \*

MedCom, Inc. announces the availability of a new project in continuing medical education—*Depression*. This project is a three-part total learning system prepared for family practitioners, surgeons, internists, obstetricians, gynecologists, teaching psychiatrists, and other physician groups.

The learning system contains a full-color documentary film, a comprehensive monograph, and

a self-evaluation section. It covers the causes, symptoms, and treatment of depression and is available at no charge for use at county society meetings, conventions, hospital staff programs, resident and intern medical programs, journal clubs, and other groups of interested physicians.

Contact Lakeside Laboratories, Inc., Milwaukee, Wisconsin 53201 to arrange for use of this material.

\* \* \*

**Donald Ernst Fisher, MD**, who practiced medicine in Elliott City for many years, has opened a medical office in St. Michaels.

Following his graduation from the University of Maryland School of Medicine in 1947, Dr. Fisher interned at Church Home and Hospital. He also did post-graduate work in pathology at the University of Maryland Hospital.

\* \* \*

**Louis J. Kolodner, MD**, assistant professor of surgery at The Johns Hopkins University School of Medicine, recently returned from a two-month world tour. During the tour, he delivered a paper at the Royal Thai Army Hospital in Bangkok, Thailand entitled, "Some Studies and Experiences in Biliary Tract Surgery".

Dr. Kolodner also met many surgeons in various countries who were former surgical trainees under him in Baltimore.

\* \* \*

The newly elected president of the Baltimore County Medical Association is **John M. Krager**,



MD, of Towson. Dr. Krager, whose term of office is for one year, was elected during the association's annual meeting in December.

Also elected to office were **Herbert Levickas, MD**, vice-president; **Baltasar Velez, MD**, secretary; and **Donald Drinkard, MD**, treasurer.

Dr. Krager, a pediatrician, is an assistant health officer and director of the Bureau of Health Supervision of the Baltimore County Department of Health. He received his bachelor's degree from Loyola College and his MD degree from the University of Maryland School of Medicine. He also received a master of public health degree from The Johns Hopkins University School of Hygiene and Public Health.

\* \* \*

**Dante U. Monakil, MD**, of Havre de Grace, was recently elected president of the Harford County Medical Society at its annual meeting in December.

Also elected were **Dudley Phillips, MD**, vice-president; **Karl Namvary, MD**, secretary; and **Edward Simon, MD**, treasurer.

A native of the Philippines, Dr. Monakil has been practicing medicine in association with two other physicians at the Union Medical Clinic in Havre de Grace since 1968.

\* \* \*

Assuming the presidency of the medical staff at St. Agnes Hospital is **Stephen K. Padussis, MD**, of Lutherville. As president, he also assumes the chairmanship of the executive committee which serves as the governing body for the hospital's medical staff.

The announcement was made by Sister Alberta, DC, the hospital's administrator. She also announced the officers of the medical staff for 1971: **B. Martin Middleton, MD**, immediate

past-president; **David McIntyre, MD**, president-elect; and **Raymond J. Donovan, MD**, secretary-treasurer.

Dr. Padussis, a graduate of Baltimore City College, received his BS and MD degrees from the University of Maryland and the university's school of medicine. He served an internship and completed his residency in surgery at St. Agnes Hospital.



Dr. Padussis

\* \* \*

Members of the **Columbia Medical Plan** enjoyed a rate of hospitalization nearly two thirds lower than that of the general population during the plan's first six months of operation. Dr. Malcolm L. Peterson, in charge of research and development for the plan, which is sponsored by The Johns Hopkins University and Hospital, added that the length of hospital stay has also been shorter.

The low hospitalization rate is attributed to the preventive care features of the plan, as well as the low number of maternity cases in the first six months, and the lower incidence of chronic disease because of the younger population.

The plan, which began operating last year, is the first to be offered by a private medical in-

stitution with total support from an insurance company.

\* \* \*

A specially equipped van for transporting donor kidneys within a 250-mile radius of Richmond, Virginia has begun operation. It went into use last fall at the Medical College of Virginia, Health Sciences Division of Virginia Commonwealth University.

The van will serve nearly all member institutions of the Southeastern Regional Kidney Procurement Group. It will also serve outlying hospitals within the 250-mile radius of Richmond that are not members of the kidney procurement group.

\* \* \*

**Martin Helrich, MD**, Professor and Chairman of the Department of Anesthesiology at the University of Maryland School of Medicine, and Chief of Anesthesiology at University Hospital, has been appointed chairman of the Advisory Committee on Respiration and Anesthetic Drugs to the Food and Drug Administration.

Dr. Helrich also serves as a consultant to Baltimore City Hospitals, the U. S. Medical Center in Bethesda, the U. S. Public Health Service in Baltimore, and the U. S. Army Hospital at Fort Meade.

\* \* \*

A new, 11-minute color film entitled "**Traitor Within**" is now available from the Maryland State Department of Health and Mental Hygiene. It points out that many people are being cured of cancer every day by surgery, radiation, or X-ray. It also emphasizes that everyone is subject to the risk of cancer and stresses the vital importance of early diagnosis and treatment.

Produced by the American Cancer Society, the film may be borrowed without charge in



Maryland from the Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston St., Baltimore, Md. 21201, or call 383-3010, ext. 8516.

\* \* \*

**George H. Greenstein, MD**, of Baltimore, was featured as a speaker at a recent meeting of the Westchester County Medical Society in New York.

\* \* \*

A new position within the Division of Maternal and Child Health of the State Health Department has been created. Filling the post as Pediatric Consultant in the division is **Yogendra Upadhyay, MD**.

Dr. Upadhyay will be responsible for improving state health services to children. His immediate priorities will be developing a screening program to detect lead poisoning; improving consultative services in child health clinics of local health departments; assisting in the implementation of the use of paramedical personnel in these clinics; and aiding in programs for the screening and early detection of handicapped children.

Dr. Upadhyay is currently a fellow in pediatrics at The Johns Hopkins Hospital.

\* \* \*

**John H. Moxley, III, MD**, Dean of the University of Maryland School of Medicine, recently addressed a medical staff meeting of the South Baltimore General Hospital.

Dr. Moxley is consultant to the Bureau of Health Professions, National Institutes of Health in Bethesda, and a member of the Council on Medical Education of the American Medical Association.

\* \* \*

**Jack Zimmerman, MD**, of Baltimore, was recently honored as a recipient of the Alumni

Achievement Award by the Alumni Association of the University of Missouri-Kansas City. Dr. Zimmerman is Chief of Surgery at Church Home and Hospital and Associate Professor of Surgery at The Johns Hopkins Hospital.

Dr. Zimmerman earned his MD degree from The Johns Hopkins University School of Medicine in 1953, where he was elected to Phi Beta Kappa. He also received his surgical training there.

In 1963, he received a MED degree from the University of Missouri-Kansas City School of Education. For six years, he served on the faculty of the University of Kansas and as Chief of Surgery at the Kansas City Veterans Administration Hospital. In 1965, he returned to Baltimore as Associate Professor of Surgery at The Johns Hopkins University School of Medicine and Chief of Surgery at Church Home and Hospital.

Dr. Zimmerman is a member of 13 professional societies and is listed in the *American Men of Science* and *Who's Who in the East*.



Dr. Zimmerman

\* \* \*

**Robert W. Gibson, MD**, Medical Director of the Sheppard

and Enoch Pratt Hospital, recently presented his Edward A. Strecker Award winning paper to the Philadelphia Psychiatric Society. The paper, entitled "Resolving the Health Crisis—Is the Psychiatrist Expendable?", was delivered at the society's annual meeting held last November.

\* \* \*

**Neil Solomon, MD, PhD**, Secretary of Health and Mental Hygiene, has praised the new state-wide **Information and Referral Service for the Aging**. The service has been established by the Health and Welfare Council of the Baltimore Area.

The new service will make it easier for elderly persons and their families to determine what resources are available to them and where and how to obtain them. Dr. Solomon has encouraged its use by those in the state in need of such guidance.

The service is headquartered in the lobby of the State Roads Commission Building at 300 W. Preston Street. The telephone number for those calling from the Baltimore area is 685-0525. The toll-free line for the remainder of Maryland is 1-800-492-0270.

\* \* \*

Two physicians who received their medical degrees from the state's two medical schools have been appointed to the faculty of the University of Nevada, Reno (School of Medical Sciences). **George T. Smith, MD**, who received his MD degree in 1956 from the University of Maryland School of Medicine, has been appointed Dean of the School of Medical Sciences. **James A. Wilkerson, III, MD**, who received his MD degree in 1958 from The Johns Hopkins University School of Medicine, is now Associate Professor of Pathology.

\* \* \*

**Irvin H. Cohen, MD**, Direc-



tor of Residency Training at the Sheppard-Pratt Hospital, recently presented two papers during the annual meeting of the Puerto Rico Medical Society in San Juan.

The papers were entitled "The Philosophy and Structure of Inpatient Psychiatric Treatment" and "Psychiatric Observations in Alopecia Areata."

Dr. Cohen also spoke to the Psychiatric Liaison Service at The Johns Hopkins Hospital in Baltimore. His topic was "Masked Depression and Other Considerations on Somatization."

\* \* \*

Hilliard Haik, MD, Secretary of the Section of Ophthalmology of the Southern Medical Association, has announced that proposed papers for the next annual meeting in November 1971 are now being accepted. If you are interested in submitting a paper, send a brief abstract to Dr. Haik at 812 Mason Blance Building, New Orleans, Louisiana. The deadline is May 1, 1971.

\* \* \*

**Victor A. McKusick, MD**, Director of the Moore Clinic of The Johns Hopkins Hospital, recently presented a series of five lectures at St. Agnes Hospital in Baltimore.

The general theme of the week-long program was "Medical Genetics." Dr. McKusick, who also serves as Professor of Medicine at The Johns Hopkins University School of Medicine, is one of the world's foremost authorities on genetic disease.

Dr. McKusick covered such topics as "General Principles of Medical Genetics", "Chromosomal Abnormalities", "Biochemical Genetics", "Inheritable Disorders of Connective Tissue", and "Genetic Counseling."

\* \* \*

**Morton D. Kramer, MD**, of Baltimore, has been appointed Chief, Sections of Neurology and

Electroencephalography, and Director of the Electroencephalography Laboratory in the Department of Medicine at St. Agnes Hospital.

The announcement was made by Sister Alberta, DC, the hospital's administrator.

Before joining the St. Agnes staff, Dr. Kramer served as Assistant Professor in the Department of Neurology at the University of Maryland School of Medicine. He was also an electroencephalographer at the University of Maryland Hospital.

Dr. Kramer received his MD degree from the University of Maryland School of Medicine and served an internship at University Hospital. He served an assistant residency in medicine at Sinai Hospital of Baltimore. This was followed by a three-year fellowship in neurology at the University of Maryland Hospital, where he then served a special fellowship in the Department of Clinical Neurophysiology and Electroencephalography.



**Dr. Kramer**

\* \* \*

The nation is slowly inching toward the metric system. This conclusion could be drawn from a special study made by the National Federation of Independent

Business at the request of the Secretary of Commerce.

The results of the survey indicate little support for a sudden change-over in the system of measurement. Most of the more than 2,000 district chairmen of the federation that were surveyed think that the change-over should be a nationally planned program extending over a period of years, with emphasis on using the metric system first started in the schools.

Currently, most druggist respondents report that they have already changed to the metric system and are using milligrams instead of grains.

Some respondents objected that they were too old to learn a new system, or that there was no need to change. Others, however, say that the change-over is inevitable and that the only concern is making a gradual change in a manner that will not be too costly to the business community.

\* \* \*

## Did You Know?

- An estimated 176 million persons—seven out of every eight Americans—have some form of hospital insurance provided by private health insurers.

- An estimated 161 million people in this country have surgical expense insurance to help pay the cost of operations.

- Persons with private health insurance received \$7.8 billion toward hospital bills in 1969, more than \$4 billion for surgical, medical and dentist fees, and \$1.6 billion to help replace income cut off by accident or illness, the Health Insurance Institute estimates.

- Overall, Americans received about \$13.5 billion from private health insurers to help pay their medical and disability income bills in 1969.

—Health Insurance Institute



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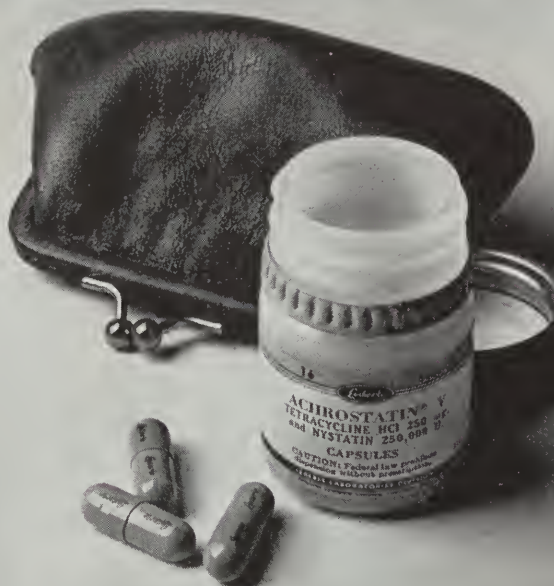
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# In Honor of Doctors' Day

March 30, 1971

*"Only a good man  
can be a great physician."*

**SIR WILLIAM OSLER**



Sir William Osler once stated that "only a good man can be a great physician." These are fitting words to remember as we again observe Doctors' Day, a day in which we honor both living and deceased physicians who gave so generously of themselves in the practice of medicine.

The idea originated with Mrs. Charles B. Almond of Georgia in 1933. And in 1935 the idea was adopted as a project of the Woman's Auxiliary to the Southern Medical Association. The red carnation was chosen as the official symbol of Doctors' Day in 1949.

The official date of March 30 was chosen to commemorate one of the great medical discoveries of freedom from pain and suffering. On this date in 1842, Dr. Crawford W. Long first used ether anesthesia in a surgical operation.

In honoring Doctors' Day, our auxiliary is making a contribution to the American Medical Association Education and Research Foundation. It is to be equally divided between The Johns Hopkins and University of Maryland schools of medicine.

A window display at the Enoch Pratt Free Library will help point out some of the great moments in medicine to the general public.

We hope that each of you has a memorable Doctors' Day.

**Mrs. Robert E. Cranley, Jr., President  
Woman's Auxiliary to the Baltimore City Medical Society**

**Mrs. William J. Marek, Chairman  
Doctors' Day**





# Medical Ethics

**JOHN F. SCHAEFER, MD**  
Baltimore

*Dr. Schaefer, President-elect of the Medical and Chirurgical Faculty, delivered this talk to the examinees taking the Federation Licensure Examination (FLEX) on December 3, 1970 in the Faculty building.*

Hippocrates enunciated the principles of medical ethics more than three centuries before the birth of Christ. In 22 succeeding centuries, men have failed to add or to take away a single tenet. Hippocrates wrote: "A physician should be an upright man, instructed in the art of healing, modest, sober, patient, prompt to do his whole duty without anxiety, pious without going so far as superstition, conducting himself with propriety in his profession and in all actions."

The physician today must be equally proficient in

the humanities and sciences if he is to succeed in his chosen career with character and competence. If he is deficient in either area, he will not be the physician his preceptors wanted him to be, nor one an enlightened public expects and demands. A physician with the finest training in ethics, morality, philosophy, and religion will develop that keen sense of sympathy and commiseration with his patients that is essential to the untroubled practice of medicine.

Ethics are principles—blueprints of experience for the practice and behavior of individuals who con-



stitute a group. Ethics distill the best of the past, sustain the needs of the present, and provide the possibilities for improvement in the future. The honest and conscientious physician may not need a written code of ethics, but one certainly can act from a right conscience only if one *has* a right conscience, and the Canon of Ethics of the American Medical Association is the guideline for the physician to use in maintaining this right conscience.

The public holds this profession in high esteem, because the large majority of physicians conduct their professional lives in accord with the principles of ethics. However, there is great tragedy in the fact that there are a few physicians who sacrifice ethics for economics, and work only for the fast dollar and their own financial gain. This group of physicians invites criticism of physicians as a whole and generally detracts from the good image of American medicine.

Any physician who places money before medicine is a traitor to his training and an early failure in maintaining this profession's highest ideals. This profession does *not* believe that its services can be bought and sold as a commodity in trade, but subscribes to the principle that the best medical services must be readily available at the most reasonable cost, and always available to the patient in need, regardless of cost.

There is a communication gap between the American public and American medicine, and this gap can best be bridged by publicizing the *Principles of Medical Ethics*, so that the public may fully understand the motivation of physicians to maintain the highest standards of ethical conduct. These principles are not laws, but are standards by which the physician determines the propriety of his conduct with patients, other physicians, members of allied professions, and the public.

**Principle 1:** The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

**Principle 2:** Physicians should continually strive to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

**Principle 3:** A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

**Principle 4:** The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the moral dignity and honor of the profession, and accept its

self-imposed discipline. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

**Principle 5:** A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged, he may discontinue his services only after giving adequate notice. He should not solicit patients.

**Principle 6:** A physician should not dispose of his services under terms or conditions which tend to interfere with, or impair, the free and complete exercise of his medical judgment and skill, or tend to cause a deterioration of the quality of medical care.

**Principle 7:** In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies, or appliances may be dispensed or supplied by the physician, provided it is in the best interest of the patient.

**Principle 8:** A physician should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of medical services may be enhanced thereby.

**Principle 9:** A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law, or unless it becomes necessary in order to protect the welfare of the individual or the community.

**Principle 10:** The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

In addition to conscientiously following the Canon of Ethics, the physician must be a good citizen, preferably a leader. He should seek an ideal balance in community and professional life. The heritage of medicine is rich, and the exacting requirements of the discipline of an "artistic science" tend to make the physician the slave of a jealous mistress. The physician must dedicate his life to man, morality, and medicine, guided by the Canon of Ethics, and consistently strive to be the most honorable man in the society which he serves.

May each one of you, in your future career, emulate all of the many great physicians in morality, ethical principle, and integrity.



JOHN B. De HOFF, MD, MPH  
Deputy Commissioner  
Baltimore City Health Department

**The**

**Vanishing**

**Diffuse**

**Outpatient**

**Department**



**Major changes in available space for ambulatory care services in Baltimore occurred from 1929 to 1969. Although changes in physician and other health manpower have been thoroughly studied, the large net loss of space which was used for ambulatory patient care in urban residential areas has received insufficient attention in planning and funding.**

As a major partner in the planning and development of the Provident Hospital Neighborhood Health Center, funded in 1967 by the Office of Economic Opportunity, the Baltimore City Health Department discovered that buildings of sufficient size to contain neighborhood health centers were difficult to obtain. Primary care centers, or medical simplexes, are needed in areas which were and still are largely residential. Many lofts or warehouses never did exist in these areas, and few suitable structures are now available. Buildings considered for the Provident Hospital project were located too distant from centers of population, or were poorly served by mass transportation, or could not be adapted to medical or health use easily or economically.

Although the need for health facilities can be met on a short-term basis by altering existing structures, we believe that long-term community health needs require totally new construction designed for health care and which are capable of being easily altered.

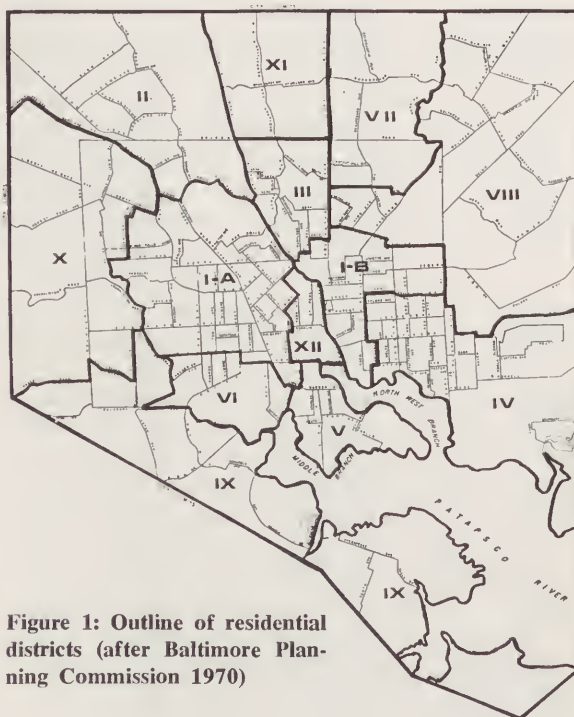
#### Method

The American Medical Association Directory for 1929 (11th edition) was used to determine the street addresses of Baltimore physicians and their type of practice. Physicians listed with hospital addresses, whose specialty was indicated, who were retired or not in practice, who were in federal or military service or local government, and those persons listed as medical school professors were not considered as generalists or primary-care physicians.

The Baltimore City Health Department's new Physician Manpower Survey was the data source for location and types of practice of physicians in Baltimore for 1969. The health department developed this computerized listing in 1967 as part of its planning for personal health services<sup>1</sup> using several physician rosters for the Baltimore Standard Metropolitan Statistical Area.\* Physicians are grouped by census tract and identified by name, address, specialty, board, qualification, professional society membership, and hospital affiliations.

Census tract population figures for 1929 were considered essentially the same as the 1930 U. S. census listings. A staff research report of the Baltimore Department of Planning<sup>2</sup> furnished 1968 population

estimates by identical census tracts, and also divided the city into 12 residential areas (Figure 1). Usual rates of annual changes are small enough to permit calculation of valid physician-population ratios using 1929-1930 and 1968-1969 figures, respectively. Census tracts were changed in 1970 and cannot easily be compared to earlier ones.



**Figure 1: Outline of residential districts (after Baltimore Planning Commission 1970)**

Office addresses of physicians listed in 1929 as nonspecialists, and considered to be generalists rendering primary care, were then plotted on a large map of Baltimore city. Similarly, office addresses listed for general practitioners and internists not board certified in 1969 were plotted. Primary physicians located in each residential district were counted for 1929 and 1969. Floor space for each physician's office was calculated at an estimated 400 square feet for each physician, and the changes resulting over 40 years were noted (Table 1). Although ratios of primary-care physicians to residential district population were calculated, these and other aspects of health manpower were considered secondary to the assessment of lost space.

\* Standard Metropolitan Statistical Area includes Baltimore city, Anne Arundel County, Baltimore County, Carroll County, Harford County, and Howard County



Residential Areas ( )	Year	Number of Primary MDs	Estimated total space (400 sq ft/MD)	Population***	Ratio 100,000 Primary MD/Pop'n
Ia	1929	272	108,800	NA	
	1969	29	11,600	177,300	16.3
	Change	—243	—97,200	—	—
Ib	1929	96	38,400	NA	—
	1969	12	4,800	94,700	12.6
	Change	—84	—33,600	—	
Ia + b	1929	368	157,200	306,140	123
	1969	41	16,400	272,000	14.7
	Change	—327	—130,800	—24,140	Decrease
II	1929	16	6,400	43,212	37
	1969	20	8,000	76,300	27.2
	Change	+4	+1,600	+33,088	Decrease
III	1929	53	21,200	40,479	134
	1969	40	16,000	37,500	106.6
	Change	—13	—5,200	—2,979	Decrease
IV	1929	93	37,200	143,927	65
	1969	24	9,600	108,400	23
	Change	—69	—27,600	—35,527	Decrease
V	1929	22	8,800	40,279	56
	1969	2	800	25,800	7.7
	Change	—20	—8,000	—14,479	Decrease
VI	1929	20	8,000	45,205	46
	1969	9	3,600	35,400	25.4
	Change	—11	—4,400	—9,805	Decrease
VII	1929	8	3,200	17,368	46
	1969	10	4,000	66,700	14.9
	Change	+2	+800	+49,332	Decrease
VIII	1929	16	6,400	64,491	28
	1969	26	10,400	135,800	19.1
	Change	+10	+4,000	+71,309	Decrease
IX	1929	2	800	29,879	6
	1969	12	4,800	74,300	16.1
	Change	+10	+4,000	+44,421	Increase
X	1929	15	6,000	38,457	39
	1969	16	6,400	86,600	18.5
	Change	+1	+400	+48,143	Decrease
XI	1929	11	4,400	14,173	77
	1969	12	4,800	18,500	64.8
	Change	+1	+400	+4,327	Decrease
XII	1929	132	52,800	13,200	1,018
	1969	51	20,400	10,400	490
	Change	—81	—32,400	—2,800	Decrease

\*\*\* Populations obtained from 1930 census and from 1968 estimates

Table 1: Changes in available amount of floor space for each primary care physician in Baltimore city—1929 to 1969

Of the 1,594 Baltimore physicians listed in the 1929 AMA Directory, 633 (39.6%) had no indication of specialty and were considered as generalists for this study. An additional 113 physicians were listed as interested in a specialty, although they did not limit themselves to its practice, and most of

The Baltimore City Physician's Manpower Survey these probably were generalists. The directory listed 352 physicians as definitely practicing a medical specialty. The remaining physicians fell into several other categories, such as those in government medical services or not in practice.



of 1969 lists 314 physicians as general practitioners and noncertified internists concerned with the primary care of patients. Although some general surgeons, gynecologists, obstetricians, internists, and pediatricians are often considered as primary-contact physicians or as personal-care physicians, these specialists were omitted from 1969 calculations because their services are somewhat limited either in extent or availability.

The 1929 AMA Directory listed 178 interns and 84 residents, a total of 262 physicians in training. The Health Department Manpower Survey for 1969 lists 1,178 interns and residents in Baltimore, with an additional 381 physicians in fellowships, a total of 1,559 physicians in training.

### Discussion

The year 1929 marked the end of a period of national prosperity and the beginning of a depressed economy. Although professional techniques changed markedly in the period from 1929 to 1949, little money was available for new construction or for relocation of offices. Most primary physicians in Baltimore maintained their offices as part of a residence. Few professional buildings existed in 1929, nor were there any groups of physicians who rendered primary care except as volunteers in hospital clinics. Thus in 1929, there was an urban distribution pattern of physicians just prior to rapid development of medical specialties, urban growth, migration to suburbs, and hospital expansion.

Hospital ambulatory care services of 1929 resembled the "medical soup kitchen" which Michael Davis described in 1914.<sup>3</sup> Only small emergency departments existed. Hospitals, located in areas of high population density and not too distant from the family physicians, maintained outpatient departments for charity patients or as a source of patients for ward service teaching.

No attempt has been made to determine space for ambulatory care services which may have been added or altered by hospitals. Construction of hospital ambulatory care services is a recent development. With few exceptions it has either been a revision of space already in use for outpatient services or a construction of outpatient departments only slightly larger than the former clinics eliminated by renovation. Any additional space thus created was offset by that which was lost when three hospitals moved from Baltimore city to Baltimore County in the late 1960's.

Formerly, most people received primary or personal health care in physicians' offices located in residential areas. Neighborhood physicians or hospital visiting staffs, in their separate offices, diagnosed and treated most acute illnesses of widely ranging seriousness, managed chronic conditions and mental illnesses, cared for pregnant women and newborn infants, performed minor surgery, and practiced ob-

stetrics in patients' homes throughout the city.

Generalists of 40 years ago furnished many of the services now supplied largely by such specialists as obstetricians, gynecologists, general surgeons, internists, and others. Because it is now impossible to estimate how much general medicine was practiced by specialists in 1929, or to what extent office gynecology, minor surgery or obstetrics was furnished by the generalists of that year, such differences in practice modes were considered to balance each other.

In effect, family physicians of 1929 and their office space represented "diffuse outpatient departments" for community hospitals. Patients obtained multiple services including emergency care at one location, with a choice of office hours, including evenings, six or seven days a week.

Based on personal knowledge and consultation with generalists formerly of this area or their physician descendants, the average floor space supplied by these "diffuse outpatient departments" for each generalist of 1929 was probably 350 to 400 square feet, perhaps as much as 500 square feet. Most of the offices were in the rowhouses common to inner Baltimore and consisted of a waiting room and an office. Occasionally there was a small room used as a laboratory or as an additional examination room. No toilets were provided for use only by patients. Little, if any, space was used by a secretary.

Not only has the actual number of generalists in central areas of Baltimore decreased markedly, but as these generalists died or moved away, office space in their homes or other residences was vacated and lost from the neighborhood as sites for delivery of primary care. As physicians moved or died, their diffuse outpatient service function shifted to nearby hospitals that were unprepared, ill-equipped, and poorly planned for this new development.

In a 1970 staff research report, the Baltimore Planning Commission divided the city into 12 "residential districts" to better show the patterns of population change in Baltimore (see Figure 1).

Areas Ia, Ib, III, IV, V, VI, VII, and IX represent the denser older residential areas of 1929, which are still predominantly residential. Area XII, the center or "downtown" area of the city, contains many specialists' offices and few generalists, as it did in 1929. These physicians do not represent a significant primary contact resource for residents of that area. Physician increases in Areas II, VII, VIII, X, and XI reflect population shifts and residential construction in the last two decades. Despite the gain in generalists for areas which experienced population growth, only one residential area had a greater general physician-population ratio in 1969. This reflects the diminishing number of generalists. We are mainly concerned with central city areas which have lost generalist physicians and where residents must increasingly depend on hospital complexes for primary care.



Table 2 shows that Wards 1 through 24 have experienced moderate to marked decreases in the white population in the last four decades. Increases in nonwhite population did not occur in all of these wards but was marked in those wards in Areas Ia and Ib. White-nonwhite information is not available from the census tracts for 1930. (See Figure 2 for the distribution of wards in Baltimore city.)

White physicians moved with the white population. Absolute numbers of Negro physicians did not increase significantly to care for the increased patient load for each physician. As the numerator of the physician-patient ratio decreased due to physician outmigration, the denominator remained the same but changed its ethnic base from white to Negro. The resultant patient load for each physician was excessive and impossible for the remaining physicians to assume, despite heroic efforts.

With fewer private physician man-hours available, the population turned in ever increasing numbers to the hospital outpatient and emergency departments.

It is in these older residential areas that the population changed in 40 years from 623,277 to 620,100,

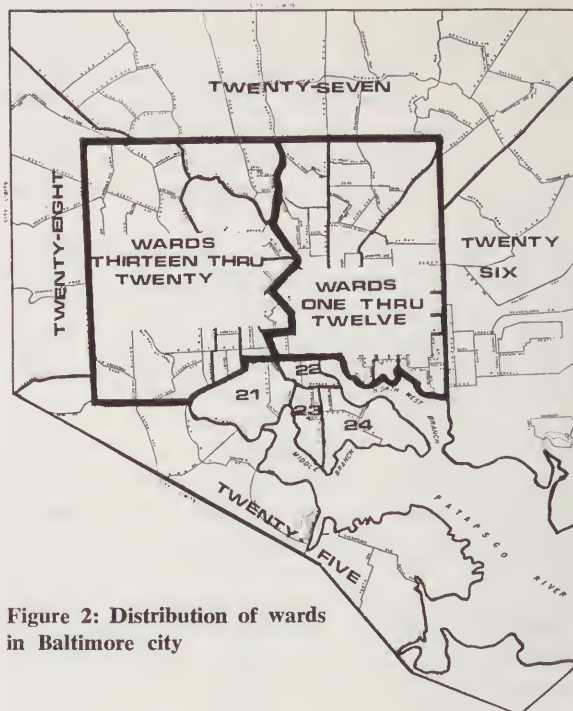


Figure 2: Distribution of wards in Baltimore city

Table 2: Changes in population makeup in Baltimore city's 28 wards

	1930 Population (U.S. Census)		1968 Estimated Population <sup>5</sup>	
	White	Negro	White	Nonwhite
<b>Total</b>	<b>664,124</b>	<b>142,106</b>	<b>515,200</b>	<b>432,400</b>
<b>Wards</b>				
1	31,218	116	18,800	0
2	17,082	229	9,600	0
3	10,495	2,637	2,200	5,100
4	6,539	4,489	2,300	4,400
5	5,058	6,913	100	7,000
6	24,570	4,387	14,700	3,900
7	23,027	8,258	11,900	11,800
8	40,493	1,792	7,500	41,100
9	39,234	1,220	19,600	26,900
10	11,855	6,476	900	12,800
11	9,808	7,026	8,100	2,700
12	33,323	4,498	22,200	12,200
13	34,526	4,055	21,100	17,200
14	7,071	15,392	2,100	13,200
15	60,626	9,795	4,300	83,700
16	28,894	17,387	900	52,900
17	1,893	14,559	300	11,500
18	7,630	9,384	4,000	8,800
19	14,126	7,237	9,300	8,400
20	43,210	738	15,900	34,700
21	14,420	2,779	8,200	2,200
22	5,899	4,940	2,100	2,200
23	11,100	2,632	7,300	2,000
24	21,154	28	13,800	0
25	21,195	1,951	46,300	20,200
26	48,295	806	93,400	600
27	74,679	2,315	145,500	31,200
28	16,704	67	22,800	15,700



a decrease of only 3,177 persons, while the general physician population dropped from 566 to 138, a loss of 428 physicians. *This represents a net loss of office space used for primary medical care of 171,200 square feet which has never been replaced.* Replacement of the 171,200 square feet calculated as lost would construct 8 to 15 neighborhood health care simplexes to serve 171,200 people, based on a minimum space allocation of one square foot for each person served.

In May 1970, there were 163,046 persons in Baltimore city who were eligible to receive Title XIX health care. At first glance, 171,200 square feet seems to meet requirements for health care of these 163,046 individuals. In 1929 it might well have been considered excessive. But in 1975 or 1979 even more space may be needed for comprehensive health centers which should include diagnostic, therapeutic, rehabilitative mental health, and social services which were not in the 1929 generalist's office.

The federal government encourages the establishment of health centers to deliver primary care, and medical schools are planning to produce more practitioners of general medicine or primary-care specialists. If these ambulatory care simplexes are to succeed, they need modern structures with sufficiently flexible design to accommodate changing health practice modes. Attention must soon be given to replacing lost service space which resulted when many physicians moved from their old offices in the residential areas.

The need to replace the vanishing diffuse outpatient department space does not resemble space needs of central city schools, fire and police departments, and other service areas. Buildings for health purposes have not simply become obsolescent; they have actually disappeared. The crowded conditions now encountered at hospital emergency departments or ambulatory care divisions result not only from more people in search of more medical care, but also because there are more people in less space than 40 years ago.

The Baltimore City Health Department has established many neighborhood clinics for the care of mothers and children and also for the treatment of certain problem illnesses. The department has played a major part since 1964 in the development of seven large ambulatory care centers now operating in Baltimore,\*\* and is helping to plan others which will supplement and extend the health care available at five health district headquarters.

### Conclusions

Freestanding new health-care simplexes or modern

\*\* *Baltimore Maternity Center, five Comprehensive Children and Youth Centers, Provident Comprehensive Neighborhood Health Center*

hospital additions are urgently needed. Construction costs cannot be met from income alone, and must be ranked high in capital expenditure priorities by administration, planners, and legislators at all levels. Space which existed in each physician's office for waiting, examination, laboratory, and other purposes must quickly be replaced.

Attempts to develop new health-care delivery systems must not be hampered by what Amdur calls the "Edifice Complex."<sup>4</sup> It must be clearly understood by all concerned people that ambulatory health-care centers require as good or better structures as the hospitals they relate to if they are to attract good health professionals and provide high quality care.

In the planning for neighborhood health centers, therefore, agencies must consider the allocation of funds to construct not only additional new space, but must plan as well to replace valuable office or treatment areas which have vanished.

### Summary

A study of primary-care physician locations in Baltimore city for 1929 and 1969 shows that an absolute loss of approximately 428 generalists occurred over 40 years. Based on a minimum estimate of 400 square feet of office space for each physician, 171,200 square feet formerly devoted to primary health care has vanished. Replacement of this space must receive serious attention when hospitals and physicians are urged to develop primary care centers geographically removed from hospitals. Additional primary medical care services can no longer be rendered in the usual hospital outpatient department, and no other suitable buildings exist for this function. Physicians, planners, and agencies should consider the need for new construction as a mandatory, overriding concern in any program to improve primary health care services.

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Juvenile pregnancy has been a growing concern to pediatricians and obstetricians because of the increase in their number<sup>1,2</sup> and an increase in the number of pediatric and obstetric complications, as noted in previous studies.<sup>1-3</sup>

Age, parity, race, social class of the mother, and quality of antenatal care have all been investigated as influencing the outcome of juvenile pregnancy.<sup>1-4</sup>

In this article we would like to evaluate the effect of the mothers' physiological maturity on juvenile pregnancy.

# Juvenile Pregnancy

## Role of Physiologic Maturity

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### Method and Material

The University of Maryland Hospital obstetric and gynecologic clinic charts were reviewed for the ten-year period 1957 to 1967, for first pregnancy in 12- to 15-year-old girls.

The chronological age of the patient was calculated from birthdate to the time of delivery. Physiological maturity is described by post menarchial age of the mother from given date for menarche until the last menstrual period before pregnancy.

### Population

Two hundred sixty-one patients' charts were available.

4—12-year-olds	148—14-year-olds
49—13-year-olds	60—15-year-olds

Ninety-four point four percent of the patients were Negro. Ten percent were married. Post menarchial age to the time of pregnancy ranged from five months to 60 months.

One hundred twenty-four patients conceived 24 months or less after menarche.

One hundred thirty-seven patients conceived more than 24 months after menarche.

### Results

The variation in age of menarche of this population is evident in Table 1. One 12-year-old girl had been menstruating more than two years when she became pregnant. Twenty-three 15-year-olds had been menstruating less than 24 months when they conceived.

**TABLE 1**  
**CHRONOLOGICAL GROUPING OF MOTHERS BY AGE ACCORDING TO PHYSIOLOGIC AGE GROUPS**

Chronological Age	24 Months Post Menarche or less	Over 24 Months Post Menarche	TOTAL
12	3	1	4
13	30	29	59
14	68	80	148
15	23	27	50
TOTAL	124	137	261

**TABLE 2**  
**LOW-BIRTH-WEIGHT AND PREECLAMPSIA OCCURRING AMONG MOTHERS UNDER 16 YEARS OF AGE BY CHRONOLOGICAL AGE**

Chronological Age	Number of Patients	Birth Weight 2,500 gm or Less		Preeclampsia	
		Number	Percent	Number	Percent
12	4	0	0.0	2	50.0
13	59	13	22.0	7	11.9
14	148	34	22.8	19	12.7
15	50	14	28.0	7	14.0
TOTAL	261	61	23.4	35	14.4

Table 2 shows little difference between chronological age groups. The number of 12-year-old mothers is too small to draw a conclusion from the absence of low-birth-weight infants or from the 50% frequency of preeclampsia.

Striking trends emerge in Table 3, where these

conditions are studied by post menarchial age. Low-birth-weight infants were born to 31.4% of the mothers who conceived 24 months or less after menarche, while only 16% of infants born to the more physiologically mature mothers weighed 2,500 gm or less. This difference is statistically significant



at the .01 level. Eighteen and one-half percent of the immature mothers had preeclampsia, while only 10.9% of the mothers who conceived more than 24

months after menarche had preeclampsia. This difference in the frequency of preeclampsia is not statistically significant.

**TABLE 3**  
**LOW-BIRTH-WEIGHT INFANTS AND PREECLAMPSIA OCCURRING AMONG MOTHERS UNDER 16 YEARS OF AGE ACCORDING TO POST MENARCHIAL AGE GROUPS**

	Number of Mothers	Birth Weight of Infant 2,500 Grams or Less		Preeclampsia	
		Number	Percent	Number	Percent
Mothers 24 months post menarche or less	124	39	31.4	23	18.5
Mothers over 24 months post menarche	137	22	16.0	15	10.9
	261	61	23.4	38	14.6
		Chi square equals 8.18		Chi square equals 1.64	

### Discussion

The normal physiological changes taking place in girls during adolescence correlate more closely with menarche rather than chronological age. This was shown by Nathan Shock<sup>5</sup> for pulse rate, blood pressure, and basal oxygen consumption. The same was shown for skeletal age vs chronological age in Greulich's<sup>6</sup> study.

Data in Table 3 are important because regardless of chronological age, physiologically less mature teenagers run almost double the risk of having a low-birth-weight infant. The frequency of preeclampsia among the physiologically more mature group is remarkably lower. These findings demonstrate the need for further study to clarify the relationship between low birth-weight and length of pregnancy in immature mothers and to extend the observations of preeclampsia in this group.

In 1922, after studying young primipara aged 12 to 16 years, Harris<sup>7</sup> concluded that from the purely obstetrical point of view, 16 years or less was the optimum age for the birth of the first baby. Later it was noted that statistical significance of younger patient data was diluted by larger numbers of individuals in the older age groups.<sup>1</sup>

Ashley Montagu described the relative sterility of adolescent girls in the two years following menarche.<sup>9</sup> This is partly explained by the irregularity of menstrual periods and the occurrence of anovulatory cycles as documented with basal temperature studies by Doring.<sup>8</sup> Our group of 124 pregnancies within this time interval emphasizes that this infertility is only relative.

In view of the declining trend in mean menarchial age in the last 100 years, as pointed out by Tanner,<sup>10</sup> we might see more chronologically young teenagers getting pregnant and, as shown in our study, chrono-

logical age will not be the best criteria to evaluate the juvenile pregnancy.

There is considerable physical growth after menarche. Mean growth after menarche is 3 inches in Dr. Smith's<sup>11</sup> study. In our clinical experience, we found an average growth of 4 inches with a range from 1 inch to 11 inches. At this moment we do not know how pregnancy affects the growth potentials of adolescent girls. To clarify our knowledge further, elements of physiologic maturity need to be studied with relation to juvenile pregnancy.

### Conclusion

In juvenile pregnancy, regardless of chronological age, the physiologically less mature teenage mother conceiving within 24 months of menarche, had twice as many low-birth-weight infants.

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# Asphyxia

## From

## Pacifier

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### Case History

A two-month-old infant was brought to the Office of the Chief Medical Examiner in Baltimore after he was found dead in his crib with a pacifier, including the rigid plastic guard, wedged in his mouth. The child had been given the pacifier and placed for a nap three hours earlier. He was in good health and normally developed. The mother stated that he tended to push his chest up and bob his head.

Extensive investigation satisfactorily eliminated foul play.

Autopsy revealed a normally developed, nourished, and cared-for infant whose mouth was widely open and contained the pacifier nipple and guard with only the rigid plastic handle protruding (see Figure 1).

A two-month-old infant died of asphyxia when he accidentally aspirated the nipple and small-diameter rigid plastic guard of a pacifier while lying prone and bobbing his head. An equally rigid handle served as a ramrod. Health advisory personnel are urged to recommend pacifiers with the larger ring and either a hinged or collapsible handle.



**Figure 1:** Appearance of child when brought to Medical Examiner's office.



Dissection of the neck revealed the nipple wedged within the posterior pharynx, totally occluding the airway, as shown in Figure 2. The guard was between the rami of the mandible and the hard palate. The tongue was pushed back. The perioral skin and mucosa of the lips showed slight bruising.



**Figure 2:** Arrow indicates nipple of pacifier. Tongue is above and larynx below the arrow.

The remaining prosection showed changes consistent with asphyxia.

#### **Comment**

A two-month-old infant died of asphyxia when he accidentally aspirated the nipple and rigid plastic guard of a pacifier. The mishap is believed to have

occurred in two steps. While prone and bobbing his head, the portion of the rim of the guard entered the infant's mouth. Subsequent bobbing against a rigid handle combined with probable further opening of the mouth in an effort to cry led to the remaining portion of the guard becoming intraoral.

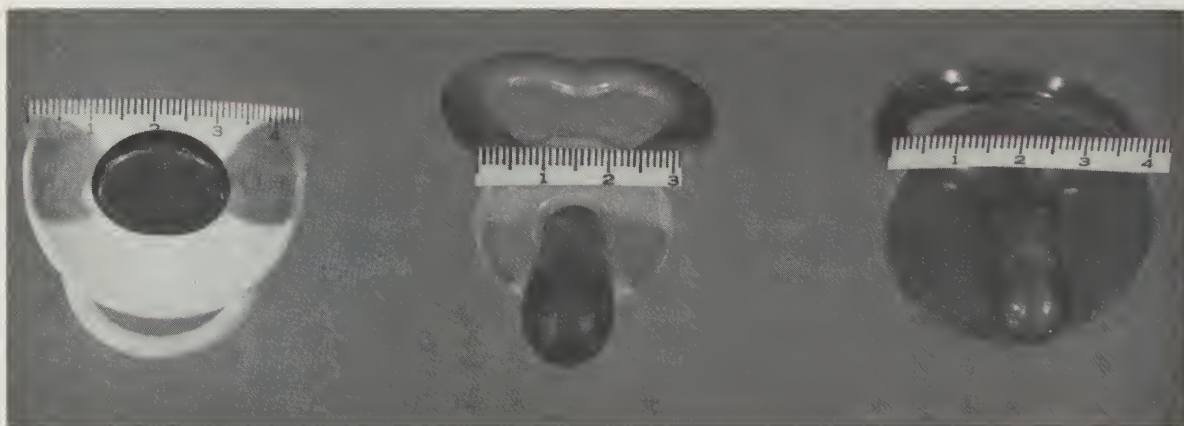
The factors of primary importance are the smaller-than-normal pacifier guard, the rigid handle that served as a ramrod, and the head-bobbing.

This small type of pacifier is to be condemned except possibly during the first month when head movement is limited.

Reports of asphyxial deaths are myriad both in quantity, variety of foreign bodies, age groups, and in association with many disease states. Review of the pertinent literature from 1963 to date revealed no other reported cases involving a pacifier with a guard. This may be due to the recent influx into the American market of this small-diameter pacifier manufactured in Hong Kong.

Review of the records of the Chief Medical Examiner of the State of Maryland revealed two other cases (in 1964 and 1966) in which a pacifier was directly responsible for the death of an infant. However, in neither case were the dimensions or other characteristics of the pacifier available.

As seen in Figure 3, the diameter of the pacifier in question is 31 mm as compared to 43 and 44 mm for American models. Random sampling of infant's departments in Baltimore area stores showed this small type of pacifier to be abundant, and in some shops it was the only type available. The American pacifiers cost 59 cents each while the foreign ones are two for 39 cents.



**Figure 3:** Comparison of the three most commonly found pacifiers in the Baltimore area.

#### **Conclusion**

This communication is intended to alert health advisory personnel to the dangers of this small-

diameter pacifier and to urge them to recommend the larger variety with the soft rubber or hinged handle.



# your medical faculty at work

by John Sargeant  
Executive Director

The Council met on Thursday, January 21, 1971, and took the following actions:

1. Amended the guidelines for therapeutic abortions so that consultations would be required only if they are required by the JCAH;
2. Accepted for information the fact that the St. Paul Companies is adopting as policy that it will not write professional liability insurance in amounts greater than \$100,000/\$300,000; but agrees to write larger amounts under its umbrella-type policy for those desiring greater coverage;
3. Approved certain proposed changes in the professional corporation law in Maryland to allow such professional corporations to use a name other than one including the incorporators, provided the name is approved by the appropriate state licensure board, and under certain other conditions;
4. Agreed to meet with the deans of Maryland's two medical schools to discuss increased enrollments and other related items;
5. Concurred in the action taken by the Baltimore City Medical Society Board of Directors, which questioned closing of the USPHS at Wyman Park without consultation with the appropriate regional planning agency;
6. Authorized to conduct further investigation with interested groups regarding formation of a Foundation for Medical Care, which would primarily deal with the question of peer review;
7. Heard the Legislative Committee report and reaffirmed the Faculty position that abortion should be a question solely between the physician and the patient;
8. Approved a recommendation that would require training and certification of ambulance attendants, and also establish minimum standards for ambulances;
9. Recommended various nominees for possible appointment to various Blue Shield boards and committees;
10. Adopted the 1971 budget;
11. Honored J. Sheldon Eastland, MD, at dinner, for his 13 years of service on the Council, as President, Past-President, and AMA Delegate.





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The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

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Be sure that statistics are consistent in both tables and text.

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**Actions**—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FHS) and the luteinizing hormone (LH).

**Special note:** Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Demulen is indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors,

some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfolobomphthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnandiol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969. 1A2

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# NEW DIMENSIONS IN MEDICINE

## 173rd ANNUAL MEETING

of the

Medical and Chirurgical Faculty of Maryland

MAY 12, 13, 14, 1971

BALTIMORE CIVIC CENTER, BALTIMORE, MARYLAND

Presenting papers during the Annual Meeting will be:

**Alan F. Guttmacher, MD**

President  
Planned Parenthood-World Population  
The Hundley Memorial Lecture in Gynecology

**G. Rainey Williams, MD**

Professor of Surgery and Chairman  
Department of Surgery  
University of Oklahoma Medical Center  
The J. M. T. Finney Fund Lecture

**George E. Schreiner, MD**

Director of Nephrology Division  
Department of Medicine  
Georgetown University School of Medicine  
The Albert E. Goldstein Memorial Lecture

**Saul Krugman, MD**

Professor and Chairman  
Department of Pediatrics  
New York University  
Harvey Grant Beck Memorial Lecture

**Lawrence K. Pickett, MD**

Professor of Pediatric Surgery and Pediatrics  
Yale University School of Medicine  
The I. Ridgeway Trimble Fund Lecture

**Nicholas J. Pisacano, MD**

Secretary  
American Board of Family Practice, Inc.  
Head  
Department of Family Practice  
University of Kentucky School of Medicine  
The George M. Boyer, MD, Lecture

**Edward C. Rosenow, Jr., MD**

Executive Director  
American College of Physicians  
The Amos R. Koontz Memorial Lecture

**Neil L. Chayet, Esquire**

Boston, Massachusetts  
The Jesse C. Coggins Fund Lecture



**MEDICAL PEDIATRIC GRAND ROUNDS**, conducted by Marvin Cornblath, MD, Professor and Head, Department of Pediatrics, University of Maryland School of Medicine, will follow the talk given by Saul Krugman, MD, on Thursday morning, May 13.

**SURGICAL PEDIATRIC GRAND ROUNDS**, conducted by J. Alex Haller, Jr., MD, Robert Garrett Professor of Pediatric Surgery, The Johns Hopkins University School of Medicine, will follow the talk given by Lawrence K. Pickett, MD, on Thursday afternoon, May 13.

**PANEL-SYMPOSIUM** on *Treatment of the Alcoholic and the Family: Practical Aspects*, conducted by Martin L. Singewald, MD, Chairman of the Committee on Medicine and Religion of the Medical and Chirurgical Faculty, has been scheduled for Wednesday evening, May 12.

#### SCIENTIFIC AND TECHNICAL EXHIBITS

Many exhibits, both technical and scientific, will be on display at the Baltimore Civic Center all during the Annual Meeting. SEE THESE EXHIBITS AND KEEP ABREAST OF SCIENTIFIC ADVANCEMENT!

#### OTHER ANNUAL MEETING ACTIVITIES

**ROUND TABLE LUNCHEON**—catered at the Baltimore Civic Center.  
Various subjects of interest to all physicians will be discussed.

**HOSPITALITY NIGHT** at the Baltimore Hilton Hotel. A fun function for all!

**PRESIDENTIAL RECEPTION AND BANQUET**—a dinner dance at the Blue Crest North.  
This will be an affair long to be remembered by all who attend.

**ART AND HOBBY EXHIBIT** at the Baltimore Civic Center. All physicians, their wives, and families are invited to complete and send to the Faculty office the application on page 65 of this Journal.

**BUSINESS MEETINGS**—Wednesday morning, May 12, and Friday afternoon, May 14.

**MORE DETAILS LATER —**

**BUT MARK THESE DATES ON YOUR CALENDAR NOW**

**MAY 12, 13, 14, 1971**

Arlie R. Mansberger, Jr., MD, *Chairman*  
Committee on Program and Arrangements



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# ART AND HOBBY EXHIBIT

## Annual Meeting of the Medical and Chirurgical Faculty

### MAY 12, 13, 14, 1971      Baltimore Civic Center

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#### APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....
  2. Amount of space required—depth, width, and height: .....
  3. Electrical or other requirements: .....
  4. Name of exhibitor: .....  
Please print
  5. Address of exhibitor: .....
  6. Telephone number of exhibitor: .....
- 


An Art and Hobby Exhibit will be held during the 173rd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to the Baltimore Civic Center, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, May 11, 1971. They must be removed on Friday, May 14, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.

A Hobby Corner at the Semiannual Meeting of the Faculty in Hershey created a great deal of interest. LET'S MAKE IT A REAL "SHOW" FOR THE 1971 ANNUAL MEETING. SUBMIT YOUR ENTRIES NOW!







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have undergone healing despite continued  
topical application of 5% 5-FU.

6/11/68

Ten weeks after discontinuance of  
therapy. All areas have healed completely.  
Residual mild erythema remains in some  
areas. This patient also had seborrheic  
keratoses which, as expected, have not  
reacted. There is no evidence of residual  
lesions or recurrences.







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## An alternative to conventional therapy

Efudex (fluorouracil) offers the physician a topical alternative to cryosurgery, electrodesiccation and cold-knife surgery in the treatment of solar/actinic keratoses. It is effective, comparatively inexpensive and especially well suited for treatment of these multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.\*

## Highly effective

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When new lesions appeared, repeated courses of Efudex therapy proved effective.\*

## Predictable therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three months before gradually receding. Since this response is so predictable, lesions which do not respond should be biopsied.

## Two strengths—two dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings

and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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**MORE ABOUT THE SPEAKERS  
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ANNUAL MEETING  
of the  
MEDICAL AND  
CHIRURGICAL FACULTY  
MAY 12, 13, 14, 1971  
at the  
BALTIMORE CIVIC CENTER**



**Saul Krugman, MD**, Professor and Chairman, Department of Pediatrics at the New York University School of Medicine, will give the Harvey Grant Beck Memorial Lecture on **VIRAL HEPATITIS**. This talk will be given on Thursday morning, May 13, during a day devoted to pediatrics.

Dr. Krugman's previous and current appointments include Director of Pediatrics, Bellevue Hospital Center and University Hospital in New York, member of the Infectious Disease Committee of the National Institute of Allergy and Infectious Diseases, Deputy Director for the Commission on Viral Infections of the Armed Forces Epidemiological Board, and Chairman of the Task Force on Rubella of the National Center for Voluntary Action. He is a member of many medical societies, one of which is the Alpha Omega Alpha Honorary Society; and he is the recipient of the Haven Emerson Award.

Board certified in pediatrics, Dr. Krugman is co-author of the book *Infectious Diseases of Children*, and his scientific contributions are reported in more than 100 articles in medical journals. His research interests are in the area of infectious diseases, with particular emphasis on hepatitis, rubella, and measles.

Following the talk by Dr. Krugman, **medical pediatric grand rounds** will be presented by **Marvin Cornblath, MD**, and his staff from the University of Maryland, where he is professor and head of the Department of Pediatrics. Dr. Cornblath was graduated from the Washington University School of Medicine in St. Louis, served a rotating internship at the St. Louis Jewish Hospital and a pediatric residency at the St. Louis Children's Hospital, and



**Dr. Cornblath**

was a postdoctorate fellow of the National Heart Institute in the Department of Biological Chemistry. His hospital appointments have included research associate and adjunct attending pediatrician at the Sinai Hospital in Baltimore; pediatrician in the OPD at The Johns Hopkins Hospital; assistant chairman of the Division of Pediatrics at the Michael Reese Hospital; and attending physician at the Cook County Hospital. Numbered among his previous academic appointments are an assistant in pediatrics at the Washington University School of Medicine, assistant professor of pediatrics at The Johns Hopkins Univer-



**Dr. Krugman**

sity School of Medicine, associate professor of pediatrics at the Northwestern University Medical School, and associate professor of pediatrics at the University of Illinois College of Medicine.

Dr. Cornblath is a diplomate of the American Board of Pediatrics, a member of many medical associations, and the author or coauthor of approximately 65 articles and books.

**Neil L. Chayet, LLB**, a well-known counsellor at law, will discuss the legal value of good health records, the legal aspects of treatments or patient management, and legal requirements for keeping up with advances in areas of general or specialized practice, including the significance or actual regulations relating to these requirements. This presentation, the annual Jesse C. Coggins Fund Lecture, will be given on Friday morning, May 14.

Mr. Chayet received his BA degree from Tufts University (magna cum laude) and his LLB degree from Harvard Law School. A practicing attorney in Boston, he is a lecturer at the Boston University School of Law and in the Department of Preventive Medicine at Tufts University School of Medicine. Mr. Chayet is also an instructor in the Department of Community Medicine at the Boston University School of Medicine; a consultant in forensic psychiatry at the Massachusetts General Hospital; a consultant in law in the Division of Psychiatry at the Boston University School of Medicine; chief consultant for research and development, and a member of the Advisory Council of the Boston University Law-Medicine Institute; member of the Research Grants Review Committee, Center for Studies of Narcotic and Drug Abuse of the National Institute of Mental Health; a member of the Boston City Hospital Committee on Human Experimentation; and a member of the Subcommittee on Law of the American Public Health Association.



by: Fabian Bachrach

**Mr. Chayet**

Mr. Chayet is author of the book *Legal Implications of Emergency Care*, and coauthor of *Trauma and the Automobile*. His other writings include articles or chapters on *Social and Legal Aspects of LSD Usage*; *Medico-Legal Aspects of Abortion*; *The Law and the Mentally Ill*; *Legal Aspects of Drug Abuse*; and *Psychiatry and the Courts: The Need for Better Communication*. He writes a monthly column and is legal editor for *Emergency Medicine*. He is also a regular contributor to *Law-Medicine Notes* in the *New England Journal of Medicine*.

See the January issue of the *Journal* for capsule biographies of Alan F. Guttmacher, MD, and Edward C. Rosenow, Jr., MD. G. Rainey Williams, MD, and George E. Schreiner, MD, are highlighted in the February *Journal*.



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MAY 12, 13, 14, 1971  
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Smith, Miller & Patch, Inc.  
E. R. Squibb & Sons, Inc.  
Symbionics, Incorporated  
Warner-Chilcott Laboratories  
Wills X-ray Supplies, Incorporated  
Wyeth Laboratories  
Hynson, Westcott & Dunning, Inc. is making a contribution, although it is unable to exhibit this year.

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# MEDIC

## 1970-1971 SCHEDULE

### OF POSTGRADUATE PROGRAMS

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**MARCH 19, 1971 — 12:30 PM**  
**ALLERGIES AND ANAPHYLACTIC REACTIONS**

**Philip S. Norman, MD**  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine  
**SPONSOR: BALTIMORE CITY HOSPITALS**

Replays: Monday, March 22, 1971 12:30 PM  
Wednesday, March 24, 1971 7:30 AM  
9:00 AM  
2:00 PM

**MARCH 26, 1971—12:30 PM**  
**NEWER DEVELOPMENTS IN EPILEPSY**

**James Kiffin Penry, MD**  
Head, Section on Epilepsy  
National Institute of Neurological  
Diseases and Stroke  
**SPONSOR: FREDERICK MEMORIAL HOSPITAL**

Replays: Monday, March 29, 1971 12:30 PM  
Wednesday, March 31, 1971 7:30 AM  
9:00 AM  
2:00 PM

**APRIL 2, 1971—12:30 PM**  
**F.U.O.—MEDICAL OR SURGICAL?**

**Philip A. Tumulty, MD**  
Professor of Medicine  
Johns Hopkins University School of Medicine  
**SPONSOR: GREATER BALTIMORE MEDICAL CENTER**

Replays: Monday, April 5, 1971 12:30 PM  
Wednesday, April 7, 1971 7:30 AM  
9:00 AM  
2:00 PM

**APRIL 9, 1971—12:30 PM**  
**SOME ASPECTS OF SHOCK TRAUMA**

**R Adams Cowley, MD**  
Professor and Head  
Division of Thoracic Surgery  
Director  
Center for the Study of Trauma  
University of Maryland School of Medicine  
**SPONSOR: ST. AGNES HOSPITAL**

Replays: Monday, April 12, 1971 12:30 PM  
Wednesday, April 14, 1971 7:30 AM  
9:00 AM  
2:00 PM

**APRIL 16, 1971—12:30 PM**  
**G.I. BLEEDING—EMERGENCY ASPECTS**

**Marvin M. Schuster, MD**  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine  
**SPONSOR: BALTIMORE CITY HOSPITALS**

Replays: Monday, April 19, 1971 12:30 PM  
Wednesday, April 21, 1971 7:30 AM  
9:00 AM  
2:00 PM

**APRIL 23, 1971—12:30 PM**  
**MIGRAINE AND RELATED HEADACHES**

**William G. Speed, III, MD**  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine  
**SPONSOR: FREDERICK MEMORIAL HOSPITAL**

Replays: Monday, April 26, 1971 12:30 PM  
Wednesday, April 28, 1971 7:30 AM  
9:00 AM  
2:00 PM

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**CONTINUING PROGRAMS**

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(Heard at participating hospitals only)

**TUESDAY MORNINGS — 11:30 AM**  
**MEDICAL GRAND ROUNDS**  
University of Maryland Hospital

**WEDNESDAYS — 12 NOON**  
**C. P. C.**  
The Johns Hopkins Hospital

**SATURDAY MORNINGS — 8:00 AM**  
**PEDIATRIC GRAND ROUNDS**  
The Johns Hopkins Hospital

**SATURDAY MORNINGS — 10:00 AM**  
**MEDICAL GRAND ROUNDS**  
The Johns Hopkins Hospital

MARYLAND STATE MEDICAL JOURNAL



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### Other locations:

Baltimore County Health Dept., Towson  
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# New Journal Subscriptions In Med-Chi Library

Among the new journal subscriptions added this year are several of varied interests and purposes.

*Adult and Child: a publication for the physician specializing in family practice and/or internal medicine* is in the third volume and essentially contains abstracts of world medical literature. It is written in easily readable type and language and the pages are perforated for tear-outs to file. Edited by Martin Brandenfonbrener, MD, of Northwestern University Medical School, the book is especially good for individual subscribers.

*The Annals of thoracic surgery*, the official journal of the Society of Thoracic Surgeons and the Southern Thoracic Surgical Association, is edited by Herbert Sloan, MD, of University Hospital in Ann Arbor, Michigan. It is published monthly and is in its 11th volume.

*Current problems in pediatrics* began November 1970, is published monthly, and is similar in format to other 'Current problems' journals. Each issue is devoted to a special subject, such as *The Newborn infant and his thermal environment* in the first issue. Forthcoming issues will feature: *Pediatric renal disease*, *Congenital heart disease*, *Learning and language disorders in children*, *Management of acute childhood poisoning*, *Drowning*, *Developmental sexuality*, and *Radiologic diagnosis of the newborn chest*.

*World meetings: U.S. and Canada*, a two-year registry of future medical, scientific, and technical meetings, is published quarterly. It contains five useful indexes: by date of meeting, keyword, location, deadline for abstracts of papers, and sponsor. Listings are revised and supplemented with each quarterly issue. It complements the *JAMA* reference directories appearing in each weekly issue of that journal. Later, the Med-Chi Library should be receiving *World meetings outside the U. S. and Canada*.

\* \* \*

### Forthcoming Library Meetings

#### Baltimore Hospital Librarians Association

Thursday, May 20, 1971—Broadview. Luncheon and election of officers, 2 PM.

#### Baltimore Chapter, Special Libraries Association

Thursday, April 22, 1971—dinner meeting (place to be announced). Speaker—Dr. Edwin Olson, Faculty of the School of Library and Information Services, University of Maryland, College Park. Topic to be announced.

Monday, May 17, 1971—Joint meeting with ASIS National Agricultural Library, Beltsville, Maryland. Dinner, tour, and annual business meeting.

### NEW ACCESSIONS—BOOKS

#### PHARMACOLOGY AND PARASITOLOGY:

**Handbook of biochemistry:** selected data for molecular biology. 2d ed. Editor: Herbert A. Sober. Advisory board chairman: Robert A. Harte. Compiler: Eva K. Sober. Cleveland, Chemical Rubber Co., 1970. QV16 H2 1970.

**Drug-induced diseases**, v. 1, 1962. Amsterdam, Excerpta Medica. Editors: L. Meyler and H. M. Peck. QV38 D7 1962.

**Fluorides and human health.** Geneva, World Health Organization, 1970. QV282 F5 1970.



Firestone, John M.

**Trends in prescription drug prices.** Washington, American Enterprise Institute for Public Policy Research, 1970. QV736 F5 1970.

James, Maurice Theodore

**Herm's medical entomology.** Maurice T. James and Robert F. Harwood. 6th ed. New York, Mcmillan, 1969. QX500 J2 1969.

#### **PRACTICE OF MEDICINE:**

Schmidt, Jacob Edward

**Structural units of medical and biological terms . . .** Springfield, Ill., Thomas, 1969. Ref. W13 S3 1969.

Carnegie Commission on Higher Education

**Higher education and the nation's health . . .** New York, McGraw-Hill, 1970. W18 C3 1970.

American College of Physicians

**Directory, 1969.** Philadelphia. W22 A4 1969.

Horwitz, John J.

**Team practice and the specialist . . .** Springfield, Ill. Thomas, 1970. W87 H6 1970.

Chayet, Neil L.

**Legal implications of emergency care.** Foreword by Robert H. Kennedy. New York, Appleton-Century-Crofts, 1969. WB100 C3 1969.

Mayo Clinic, Rochester, Minn. Committee on Dietetics.

**Mayo Clinic Diet Manual.** 4th ed. Philadelphia, Saunders, 1971. WB400 M2 1971.

Grossman, Charles C.

**Diagnostic ultrasound;** proceedings of the first international conference, University of Pittsburgh, 1965. New York, Plenum Press, 1966. WB515 G7 1965.

#### **PUBLIC HEALTH:**

Anderson, Wayne J.

**How to discuss sex with teen-agers; . . .** Minneapolis, Denison, 1969. HQ56 A6 1969.

Linton, Ron M.

**Terracide;** America's destruction of her living environment. Boston, Little, Brown, 1970. WA30 L5 1970.

McKeown, Thomas

**An introduction to social medicine.** By Thomas McKeown and C. R. Lowe. Philadelphia, F. A. Davis Co., 1967. WA30 M2 1967.

Wain, Harry

**A history of preventive medicine.** Springfield, Ill., Thomas, 1970. History WA110 W2 1970.

U.S. Social Security Administration. Bureau of Health Insurance.

**Directory of medicare providers and suppliers of services . . .** 1970. Ref. WT22 U6 1970.

Maryland Hospital Education & Research Foundation, Inc., Health Careers Program.

**Health careers;** a guide to educational and training programs in Maryland. Lutherville, Md., 1970. WX159 M2 1970.

#### **INFECTIOUS AND DEFICIENCY DISEASES:**

Moss, Emma Sadler

**Atlas of medical mycology.** Emma Sadler Moss and Albert Louis McQuown. 3d ed. Baltimore, Williams & Wilkins Co., 1969. WC450 M6 1969.

Timbury, Morag Crichton

**Notes on medical virology.** Foreword by J. H. Subak-Sharpe. 2d ed. Edinburgh, Livingstone, 1969. WC500 T5 1969.

Aikawa, Jerry Kazuo

**Rocky Mountain spotted fever.** Springfield, Ill., Thomas, 1966. WC620 A4 1966.

Stewart, Gordon Thallon

**Penicillin allergy;** clinical and immunological aspects. Edited by Gordon T. Stewart and John P. McGovern. Springfield, Ill., Thomas, 1970. WD320 S7 1970.

Feucht, James R.

**Common poisonous plants in home and grounds.** (Colorado State University, For Collins. Cooperative Extension Service. Bulletin, 466A). WD500 F3 1969.

#### **RESPIRATORY AND CARDIOVASCULAR SYSTEMS:**

National Tuberculosis & Respiratory Disease Association.

**Diagnostic standards and classification of tuberculosis,** 1969. New York, 1969. WF220 N2 1969.

Altman, Philip Lawrence

**Respiration & circulation.** Edited by Philip L. Altman and Dorothy S. Dittmer. Bethesda, Federation of American Societies for Experimental Biology, 1971. (Biological handbooks). QT16 A5 1971.

Hume, Michael

**Venous thrombosis and pulmonary embolism.** By Michael Hume, Simon Sevitt and Duncan P. Thomas. Cambridge, Harvard University Press, 1970. WG610 H8 1970.

#### **GASTROINTESTINAL AND UROGENITAL SYSTEMS:**

Klinkhamer, A. C.

**Esophagography in anomalies of the aortic arch system.** Amsterdam, Excerpta Medica Foundation, 1969. W1250 K5 1969.

American Association of Genito-Urinary Surgeons.

**Transactions.** v. 62, 1970. Dallas. WJ1 A5 1970.

Campbell, Meredith Fairfax

**Urology.** Edited by Meredith F. Campbell and J. Hartwell Harrison, with the collaboration of 74 contributing authorities. 3d ed. Philadelphia, Saunders, 1970. WJ100 C2 1970.

#### **NERVOUS SYSTEM AND PSYCHIATRY:**

Jennett, W. Bryan

**An introduction to neurosurgery.** 2d ed. St. Louis, Mosby, 1970. WL368 J4 1970.

Sherman, Murray Herbert

**Psychoanalysis in America;** historical perspectives. Edited by Murray H. Sherman, with the cooperation of Marie Coleman Nelson, Benjamin Nelson, and Donald M. Kaplan. Springfield, Ill., Thomas, 1966. History WM11 S4 1966.

American Psychological Association.

**Directory, 1970.** Washington. Ref. WM22 A5b 1970.

Mayer-Gross, Willy

**Clinical psychiatry.** 3d ed. By Eliot Slater and Martin Roth. Baltimore, Williams & Wilkins, 1969. WM100 M2 1969.

Society for the Study of Addiction to Alcohol and Other Drugs.

**The pharmacological and epidemiological aspects of adolescent drug dependence;** proceedings of the Society for the Study of Addiction. Edited by C. W. M. Wilson. Oxford, New York, Symposium Publications Division, Pergamon Press, 1968. WM270 S6 1966.

Sheehan, Joseph G.

**Stuttering; research and therapy.** New York, Harper & Row, 1970. WM475 S4 1970.



## SURGERY:

European Society for Experimental Surgery.

**Abstracts of papers presented** at the 2d congress, Louvain, Belgium. (Excerpta Medica. International congress series, no. 152). WO50 E8 1967.

Norris, Walter

**Anaesthetics, resuscitation, and intensive care;** a textbook for students and residents. By Walter Norris and Donald Campbell. 2d ed. Baltimore, Williams & Wilkins, 1968. WO200 N6 1968.

International Symposium on Pharmacological Treatment in Burns, Milan, 1968.

**Pharmacological treatment in burns;** proceedings. Editors: A. Bertelli and L. Donati. Amsterdam, Excerpta Medica, 1969. (Excerpta medica. International congress series, no. 190.) WO704 I6 1968.

Swenson, Orvar

**Pediatric surgery.** 3d ed. New York, Appleton-Century-Crofts, 1969. WO925 S8 1969.

## OBSTETRICS AND GYNECOLOGY:

**Advanced concepts in contraception.** Proceedings of four symposia. Edited by Fredric Hoffman in collaboration with Ronald L. Kleinman. Amsterdam, Excerpta Medica, 1968. (International congress series, no. 169). WP630 A2 1968.

Calderone, Mary Steichen

**Manual of family planning and contraceptive practice.** 2d ed. Baltimore, Williams & Wilkins, 1970. WP630 C2 1970.

Sweering, Ronald

**The birth of a child;** a doctor's-eye-view documentary of a child being born. Text by Ann Dally. Photos by Ronald Sweering. With a foreword by Josephine Barnes. With an introduction to the American edition and modification of the text by Alan F. Guttmacher. New York, Crown Publishers, 1969. WQ150 S3 1969.

## DERMATOLOGY:

Braverman, Irwin M.

**Skin signs of systemic disease.** Philadelphia, Saunders, 1970. WR140 B7 1970.

Lewis, George Morris

**Practical dermatology.** By George M. Lewis and Clayton E. Wheeler. 3d ed. Philadelphia, Saunders, 1967. WR140 L4 1967.

## OPHTHALMOLOGY:

European Ophthalmological Society.

**Third congress of the European Society of Ophthalmology.** Amsterdam, New York, Excerpta Medica Foundation, 1968. WW100 E8 1968.

## HISTORY OF MEDICINE:

Flexner, Simon

**William Henry Welch and the heroic age of American medicine.** By Simon Flexner and James Thomas Flexner. New York, Viking Press, 1941. History WZ100 W3 F5 1941.

Williams, Stephen West

**American medical biography;** or, Memoirs of eminent physicians; embracing principally those who have died since the publication of Dr. Thacher's initial work in 1828 on the same subject. New York, Milford House, 1967. History WZ112 W5 1967.

## BIBLIOGRAPHY:

Vernick, Joel J.

**Selected bibliography on death and dying.** Bethesda, U.S. National Institute of Child Health and Human Development, 1970. ZBD444 V3 1970.

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## Maryland State department of health and mental hygiene

# Major Legislative Proposals - 1971

The Department of Health and Mental Hygiene sponsored some important General Assembly bills in 1970, which were not enacted. Some of these were referred to the 1970 Legislative Council where they were reviewed and modified. They have been introduced as Legislative Council bills in the form of Senate bills numbers 4, 12, 13, and 21.

New important Legislative Council bills are Senate bills numbers 8, 9, 10, and 11, which the department supports.

Another bill to be introduced is a state milk law. The department plans to amend its present law so that all mental retardation services can be consolidated and given departmental status, plus other reorganization items.

A brief synopsis of each bill follows:

**Senate Bill No. 4—MARYLAND, FOOD, DRUG & COSMETIC ACT:** To repeal Secs. 187 through 191, inclusive, and to enact new Secs. 187 through 191E, inclusive, of Art. 43 of the code, relating generally to the laws of Maryland concerning food, drugs, devices, and cosmetics and to the administration and enforcement of laws dealing with these matters.

**Senate Bill No. 12—STATE COMPREHENSIVE HEALTH PLANNING AGENCY:** To add new Sec. 59C(f) to Art. 41, and to amend Secs. 556 and 559(a-1) and add new Sec. 562A to Art. 43 of the code, to include certain related institutions operated for profit under the hospital regulation law, to expand the definition of "related institutions," and to make certain provisions concerning the State Comprehensive Health Planning Agency under the hospital regulation laws.

**Senate Bill No. 13—HEALTH SERVICES COST AGENCY:** To add new Secs. 568H through 568S, inclusive, to Art. 43 of the code, to establish a Health Services Cost Agency, provide for its administration, powers, duties and functions, and provide for certain regulations of health institutions in the state of Maryland.

**Senate Bill No. 21—HEALTH—PLUMBING:** To add new Sec. 54C to Art. 43 of the code, to provide that the Secretary of Health and Mental Hygiene shall promulgate up-to-date plumbing regulations.

**Senate Bill No. 8—HEALTH:** To repeal Sec. 42A of Art. 43 of the code, to repeal the requirement that the counties and Baltimore city pay a designated percentage of cost for hospital care of indigents and medical indigents.

**Senate Bill No. 9—MENTAL HYGIENE:** To repeal Sec. 45 and to enact new Sec. 45 of Art. 59 of the code, to repeal the requirement for payment of a specific sum annually to the state by the counties for care of patients in state mental health facilities, and to restate the responsibility of the state, the patient, and others for payment of care of patients in mental health facilities.

**Senate Bill No. 10—HEALTH—EYEGLASSES:** To add new Sec. 54C to Art. 43 of the code, to provide safety standards for eyeglass and sunglass lenses and frames and to provide a penalty for violations.

**Senate Bill No. 11—HEALTH—CHRONIC HOSPITALS:** To amend Sec. 601(e) and to



repeal Secs. 601(e-1), (e-2), and 602 of Art. 43 of the code, to repeal the requirement for payment of specific sums to the state by the counties and Baltimore city for the cost of care of patients at state chronic disease hospitals.

**New Legislation—MILK PRODUCTS:** To repeal certain sections and to add certain new sections of Art. 43 of the code to establish a uniform law relating to production, processing, labeling, and distribution of graded milk products, and providing criminal penalties for violations.

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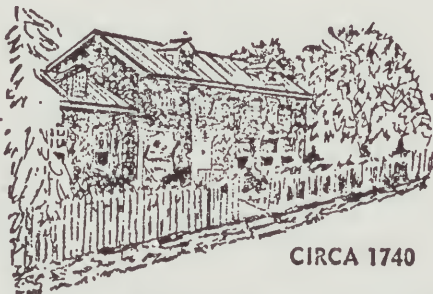
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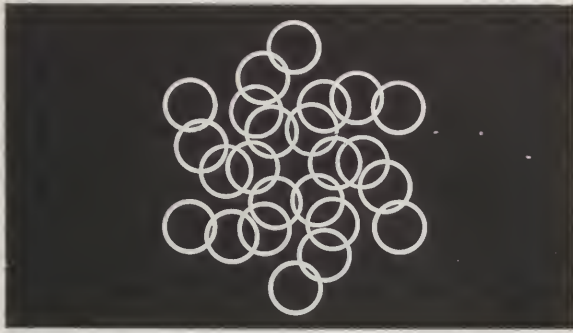
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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
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## alcoholism section

# Interdisciplinary Alcoholism Education for Medical and Paramedical Personnel

ANTHONY J. READING, MD  
TORREY C. BROWN, MD  
Departments of Medicine and Psychiatry  
The Johns Hopkins University School of Medicine  
Baltimore

*This article is based on a paper entitled "Recent Advances in Studies of Alcoholism", presented at the N.I.M.H. Symposium in Washington, D.C. in June 1970.*

Alcoholism presents a twofold challenge to the medical profession. There is certainly a pressing need to extend the frontiers of our basic understanding of alcoholism. Equally urgent, however, is the need to translate the knowledge that is already available into effective treatment programs. Both of these areas, until very recently, have been greatly neglected by traditional medicine. If we are to deal effectively with the problem of alcoholism, we can no longer afford to neglect either area. This article will focus on the second area by describing an attempt to introduce currently available knowledge and techniques into an ongoing health care system.

### The Alcoholic in the Health Care System

It is no longer a secret that the health care system is far from well. Much has recently been written about its high cost, its fragmentation and inefficiency, its impersonality, and its inability to equally meet the needs of all segments of society. It is our contention that the alcoholic is the prime victim of the deficiencies of the system, since his illness transcends the traditional boundaries between medical specialities and disciplines. A large, urban teaching hospital, such as the one in which this program has been initiated, clearly exemplifies both the assets and the liabilities of the current health system.

In the community that surrounds our hospital, there is only one physician for every 7,000 people, compared to the national average of one physician for every 1,000 people. All the indices of poor medical care are present. The rates of venereal disease,

tuberculosis, infant mortality, diabetes, hypertension, and heart disease are all significantly higher than state and national averages. So also are the rates of poverty, unemployment, and crime. For persons living in this area, the rate of admission to state mental hospitals for alcoholism (12 per 1,000) is eight times greater than the rate for the rest of the state.

However, an even greater number of alcoholics are admitted to the wards of our general hospital. Twenty-one percent of all admissions to the medical service of the hospital, for example, are the result of excessive alcohol consumption, while 12% are for unrelated medical conditions in alcoholics.

Prior to the onset of the present program, no outpatient alcoholism treatment services were offered. Instead, the alcoholic had to negotiate a system com-



prised of 144 specialty clinics in 53 different locations, none of which accepted responsibility for his drinking problems *per se*. Typically, he had to attend the surgical clinic for his injuries, the neurological clinic for seizures, the hematological clinic for his anemia, the gastroenterological clinic for liver disease, and the psychiatric clinic for his emotional problems. While he received thorough and high-quality care for all the secondary manifestations of his illness, much of what was accomplished was later undone through failure to attend to his underlying drinking disorder. For the more severe cases of alcoholism, negotiating the clinic system seemed impossible. Most of their ambulatory care was rendered in an already overburdened emergency department, thus ensuring absolute discontinuity. With regard to the alcoholic, then, it seemed that the system produced only despair and frustration, both for the staff and for the patient. It also seemed that in order to implement any changes, the system would first have to be organized. Otherwise, there was the danger that an additional program would only increase the confusion.

### Formulation of an Educational Strategy

The aim of the program was to render the present system more effective, rather than to create a competing system. The first step was to identify those aspects of the system which seemed most susceptible to change. Five basic features of the system were identified as critically important in forming our educational strategy. These were as follows:

1. **Existing educational system:** We observed that a highly effective educational system was already in operation. It wasn't that the staff was not being taught about alcoholism; rather, each new staff member was being systematically inculcated with various myths and prejudices about alcoholism and the alcoholic. Thus, we decided that any specific educational program would be doomed unless we could significantly alter the unfavorable aspects of the hospital's culture.
2. **Dissemination of information:** Compared to its other medical interests, the hospital had demonstrated a remarkable resistance to learning about advances in the treatment of alcoholism. It seemed that the hospital simply had no mechanism for incorporating or transmitting such information into its system. All of the existing channels for the dissemination of new information were designed exclusively for within-specialty or within-discipline needs. Therefore, we decided that it would be necessary to develop a system for the effective dissemination of new information to all personnel involved in the care of alcoholic patients.
3. **Service component:** As in other areas of medi-

cine, we believed that we could best teach clinical skills in alcoholism through example and precept, rather than through formal instruction. We also felt that the most effective opportunity for the interchange of information between different medical disciplines occurs when their members discuss particular clinical cases. Thirdly, we believed that we should become directly involved in helping care for the alcoholic patients. Therefore, we decided that the educational program would be sterile and ineffective unless it was intimately involved with developing a competent service program.

4. **Specialized skills:** We decided that no matter how successful we were at educating the existing staff or at using skills that were already present in the system, certain critical aspects of care would still be lacking. In order to make the system completely competent in caring for alcoholic patients, we would have to hire certain specialized personnel. Their function would be to provide only those services that the system itself was not capable of providing. Indeed, one of our initial hypotheses was that much of the hospital's negative attitude towards alcoholics was the result of the staff's frustration in working with a system that lacked this competence.
5. **Administration:** No single unit within the traditional hospital structure seemed sufficiently broad to encompass the administrative diversity presented by the alcoholic. The sharing of responsibility across traditional boundaries was deemed essential. Accordingly, the program became a joint enterprise of the departments of medicine and psychiatry, with active support from the department of social work and the division of nursing.

### The Educational Program

The program that resulted had four main educational components: the training of a specialized staff; the reeducation of existing hospital personnel; the education of new personnel as they were recruited to the system; and the establishment of continuing education programs for all relevant members of the hospital staff. In becoming operational, however, the program that developed was, of necessity, largely determined by the economic realities that confronted it.

The program was initiated about 1½ years ago when the medical system was experiencing great economic difficulty. Rather than wait for adequate financing, we decided to proceed with a minimal cost program. It seemed to us that, in this particular field and at this particular time, further support would most likely be forthcoming only after we had demonstrated the program's usefulness. While the



financial conditions have obviously limited the rapidity of the program's development, they also illustrate how much can be accomplished within given economic conditions. In fact, we feel strongly that the demonstration of general economic feasibility must be a prime consideration in the translation of knowledge into practice. The implementation of the program to date is briefly described below.

### **Specialized Staff**

One year before our program was begun, the Baltimore City Health Department had started a training program for alcoholism counselors. These counselors were high school graduates, often ex-alcoholics, and mostly local community residents. Four of their six months of training was in supervised field work, and our program began with the placement of four such trainees in the hospital. Subsequently, we were able to employ a number of graduate counselors. Much of our program has been built around their deployment.

The objective has been to integrate the counselors into the existing system. Thus, the counselors are available throughout the hospital as consultants to the medical and nursing staff about their alcoholic patients. The counselors provide information on relevant resources within the hospital and within the community for these patients, provide counselling to the patients about their drinking problems, and help coordinate the various aspects of their care. After the initial six months of operation, a full-time nurse was employed to supervise and coordinate these activities. During the first year of operation, the counselors had 920 patients referred to them, two thirds of whom were placed in alcoholism treatment programs.

Through a program of supervision, seminars, and staff meetings, the counselors are exposed to a continuing educational process designed to increase their clinical skills and medical sophistication, to help them better integrate their efforts with the other hospital services, and enable them to deal more effectively with the other hospital staff. During the second half of the initial year, a halfway house for alcoholic patients of the hospital and an outpatient alcoholism clinic were developed with counselors as staff.

### **Reeducation**

The goals of this program were to alter the unfavorable attitudes and outdated practices that existed in the care of alcoholic patients. As the alcoholism counselors were introduced, their interest and enthusiasm proved to be somewhat infectious. Initial skepticism and caution began to dissipate as the service program began to produce demonstrable results. Much of the frustration and rejection also began to disappear as the staff realized that their

specialized efforts were no longer being wasted.

The design of the service program provided that the counselors work closely with the other hospital personnel, feeding information back to them as part of the consultative process. One of the aims of this was to teach the staff to discriminate between alcoholics, rather than against them. Once the staff was able to conceive of a particular patient as an individual and not "just another alcoholic", they were often able to see ways in which their traditional skills could better be used in treating the patient. Some measure of the acceptance of the program is shown by the fact that while initially some 34% of the patients referred to the counselors refused the services offered, within four months this had been reduced to 6%. The main focus of these efforts was where the alcoholics were—in the emergency room and on the medical wards. The medical and psychiatric house staff, the nursing staff at all levels, the social workers, and the administrative staff were all involved.

As a second part of our reeducational effort, we felt that it was essential to attempt to legitimize the treatment of alcoholism within the medical system. It seemed that no matter how often the courts and the legislature had defined alcoholism as an illness, the definition still remained largely an academic question as far as the health care system was concerned. Rather than resort to preaching or exhortation, we decided to define alcoholism as an area of operational medical concern. We attempted to do this through maintaining a high visibility for our service program, by closely associating it with the traditional aspects of medical care, and by ensuring appropriate status and support for our counselors.

In addition, we took pains to locate our outpatient alcoholism clinic among the other medical specialty clinics, to prominently advertise all our open lectures and seminars, and to introduce Alcoholics Anonymous into the main part of the hospital. This group now holds its weekly meetings in the Doctors' Dining Room. The public relations department also covered our program in the hospital's staff magazine as well as in local newspapers and television specials.

As a third part of our attempt to favorably alter the hospital culture, we have attempted to provide alcoholism services to the hospital's own personnel. The hospital is one of the largest employers in Baltimore city and has its share of alcoholic employees. We feel that the demonstration of effectiveness at this level has an immense educational impact throughout the system.

### **Recruits**

Each year, many new individuals are recruited into the health care system. We are particularly interested in educating medical and nursing students



about alcoholism early in their careers. Since efforts to change formal curricula are difficult, we have placed our initial emphasis on the more flexible parts of their training programs.

For the medical students, a number of elective opportunities have been developed. One group of approximately 12 freshmen medical students has undertaken night-time coverage of our halfway house as part of a community project. Another six students have worked in the alcoholism clinic as part of an elective quarter, while four others have been supervised in alcoholism research projects during elective time. During the academic year, an elective monthly dinner-seminar was held, often with outside speakers invited. The alcoholism nurse has also been instrumental in establishing programs for the nursing students. These now include seminars for nurses on the inpatient service and a three-week rotation through the alcoholism clinic while they are working in the outpatient service.

Efforts have also been directed at training other new personnel, such as the medical corpsmen and the mental health counselors. It has been our experience that opportunities for participating in the training of new personnel have only presented themselves as the other aspects of the program have been developed. We anticipate that they will continue to expand over time.

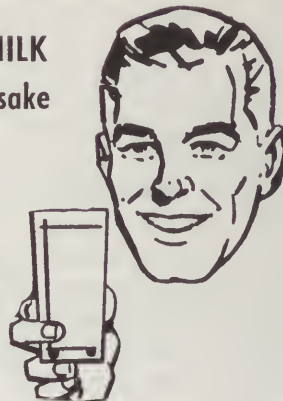
#### Continuing Education

It has already been mentioned that the hospital lacked a mechanism for the incorporation and dissemination of new information about alcoholism. To some extent, the service program provides such a vehicle, especially with its insistence on the interaction of the alcoholism staff with the other personnel. As they become the main source from which such new information diffuses into the system, it is essential that the staff be acquainted with current progress in the field. They are thus encouraged to keep abreast of the relevant literature and to attend local and regional educational programs. Special efforts are made to identify and to work with those individuals in the system who are especially influential in determining its treatment practices. To date, a number of such individuals have become sympathetic to the program and have been extremely helpful in magnifying the efforts of our staff by inserting relevant information into existing communication channels.

All of these educational efforts are still in progress. The results to date have been sufficiently encouraging for all those involved to keep working at developing the program. Whether or not the program will ultimately achieve its goals will, however, largely depend upon its success in economically justifying its existence and in attracting the necessary financial support.

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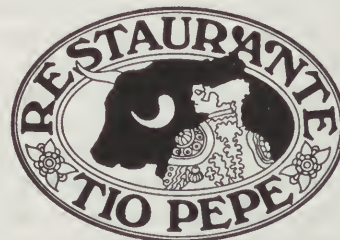
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MIRIAM L. COHEN, MD, EDITOR

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## the heart page

# Atrial Septal Defect in the Adult

J. O'NEAL HUMPHRIES, MD

Johns Hopkins University  
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Congestive heart failure complicated by or precipitated by atrial fibrillation or flutter in middle age is the expected presentation of most patients with an atrial septal defect (ASD). Lack of understanding of the natural history of an atrial septal defect makes this a frequently missed diagnosis. Recognition and confirmation of the presence of an atrial septal defect as the cause of congestive heart failure is most important since operative correction can be accomplished with a low mortality and results in dramatic improvement or elimination of symptoms.

The study of the natural history of patients with atrial septal defects shows that only one patient in 100 will develop heart failure in infancy. Another 20 will develop an elevated pulmonary vascular resistance during adolescence or the third decade of life. These patients develop extreme fatigue, chest pain, syncope, cyanosis, and eventually right heart failure. Sudden death may occur.

Evidence of right ventricular hypertrophy dominates the clinical presentation of the patients in this group. The ventricular heave along the left sternal border is forceful and the second sound in the second left interspace is very loud and only narrowly split. Cyanosis is mild but is accentuated by exercise. The electrocardiogram (ECG) and chest X-ray show changes of right ventricular hypertrophy. Cardiac catheterization shows a pulmonary vascular resistance of at least three quarters the systemic vascular resistance. Though the septal defect may be large, the shunt of blood through the defect will be small because of the high pulmonary vascular resistance.

Surgery to close the septal defect in this group is very risky and the benefits limited. The prognosis with or without surgery is poor. Progressive limitation due to low cardiac output leads to death in one

to ten years despite medical therapy including digitalis, diuretics, and anticoagulation.

The vast majority, or about 80%, of patients born with an atrial septal defect will not develop severe elevation of the pulmonary vascular resistance and will continue essentially asymptomatic until the onset of heart failure at age 35 to 75 years. Unfortunately, the signs and symptoms of heart failure due to atrial septal defect are exactly the same as those of heart failure of any etiology. When these develop in the fourth, fifth, sixth, or even seventh decade of life, it is no wonder that myocardial or valvular heart disease is suspected as the etiology. The presence of atrial fibrillation or flutter adds to the similarity between septal defect and rheumatic valvular disease.

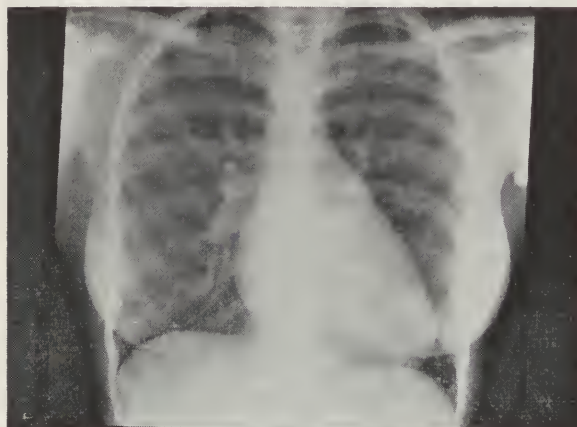
Further confusion is added by mid-precordial murmurs which are characteristic of rheumatic valvular disease but may also be present in atrial septal defect. Large or torrential flow of blood through the tricuspid valve in ASD causes a mid-diastolic rumble. A holosystolic murmur may be heard as a consequence of tricuspid regurgitation which often develops with right ventricular failure.

After the onset of failure, the classical signs of



atrial septal defect are present but may be difficult to identify. These include wide-fixed splitting of the second heart sound and a prominent ejection-type systolic murmur in the second and third left intercostal space. The second component of the split sound may be mistaken for an opening snap of mitral valve disease.

The identification of a right bundle branch block on the ECG may be the initial clue that heart failure in the middle-aged patient is due to an atrial septal defect. Even more specific, however, is the prominence of the pulmonary arterial vessels on the chest X-ray, as seen in Figure 1.



**Figure 1:** Typical posteroanterior X-ray view of the chest showing enlargement of all chambers of the heart and prominence of the pulmonary arterial vessels in a patient with an atrial septal defect

Once atrial septal defect is suspected, the diagnosis should be confirmed by cardiac catheterization and angiography. This study should also establish the type of septal defect, rule out other cardiac disease, and quantitate the pulmonary vascular resistance.

Surgical correction of the septal defect can be accomplished with a low risk. The earlier in the course of the illness that surgery is done, the lower the risk. In fact, before the development of symptoms, the uncomplicated atrial septal defect can be closed with the usual risk of anesthesia, blood transfusion, and medication. After successful closure, a normal life expectancy is anticipated. Once heart failure occurs, the risk of surgery is slightly greater, but still only about 1% to 2%, and the prognosis after successful closure is dependent on the severity of myocardial damage and complicating arrhythmias. Without surgery, continuing difficulty with heart failure can be expected. Thus, except when the pulmonary vascular resistance is elevated, surgical closure of an atrial septal defect in an adult should be performed when the defect is recognized and confirmed.




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DOUGLAS G. CARROLL, MD, EDITOR

## rehabilitation notes

# Patterns of Medical Care in a Municipal Hospital: Prediction of Rehabilitation Accomplishment in a Chronic Disease Hospital

"In identifying the results of treatment, effective indexes and criteria have not been systematically established for assessing post-therapeutic accomplishment. For example, physicians regularly talk about the 'palliative' treatment of cancer, but we do not assess the patient's palliation in terms of relief of pain, or ability to perform acts of daily life; we usually assess only his survival time, his white-cell count or the size of his tumor.

If the 19th century and early 20th century gave physicians quantified precision in the diagnosis of disease, we now need a quantification of prognosis. This activity will require large-scale clinical epidemiologic studies of the course and outcome of disease in patients for each part of the diverse clinical spectrum of each disease. Such studies have generally not been planned or performed in a manner satisfactory for modern science.

We also need data about the quantification of therapy, obtained from carefully designed surveys and prospective trials of therapeutic agents, with adequate attention given to the diverse kinds of clinical details that differentiate the patients who are involved."<sup>1</sup>

In 1957, a survey<sup>2</sup> of the medical, nursing, and rehabilitation needs of 230 medical patients in the Baltimore City Chronic Disease Hospital was made. It was estimated that 61% of the patients needed only nursing care, 18% needed constant medical and nursing care, and 21% showed possibilities of discharge with rehabilitation and intensive medical care. As a result of this survey, the whole philosophy and method of admission and care of patients with chronic diseases being referred to the Baltimore City Hospitals was changed.

All patients selected for admission to the Baltimore City Chronic Disease Hospital were first ad-

mitted to the acute medical wards for complete diagnostic review and treatment, before being transferred to the chronic hospital. This step was considered the essential foundation in the care of patients with chronic diseases. While in the acute hospital, the patient's social investigation was started, members of his family were interviewed, and he was seen in the department of physical medicine and rehabilitation. Because of limited personnel and equipment, one of the essential questions asked was whether the patient could benefit from rehabilitation. If the patient was already at maximal physical, emotional, social, and vocational potential, plans could



be made for long-term care or for transfer to a more appropriate institution.

This study was undertaken to answer the question, "How well can the physician predict physical performance in activities of daily living in a patient disabled by a chronic disease?"

### Material and Methods

As of May 1968, there were 260 patients in the chronic disease hospital. Some of these patients had been in for long periods of time; most had been in less than a year.

All patients had an ADL score<sup>3</sup> and a MSCL score<sup>4</sup> performed and were seen for general review. A prediction was then made as to what functional group<sup>3</sup> the patient would be expected to attain during his stay in the chronic hospital. Prior to discharge, the ADL score was repeated. All patients still in the hospital at the end of one year had the ADL score repeated.

There were five prognostic groups into which the patient might be placed when first seen.

**Group 1** included patients with an ADL score of 96 to 100. This initial prediction meant that the patient would be able to do all activities of daily living including feeding, dressing, and bathing him-

self, walking, and step climbing. He would also be continent of urine and feces at the end of the treatment period, or one year. Since this system of prediction is an attempt to measure change, Group 1 can only be applied to patients who have improved in function starting at a lower level of function. That is, a patient who is already independent, with an ADL score of 100, would not be placed in this group since he might finish with an ADL score of 100, but would not have improved. Instead, he would go into Group 4 (below).

**Group 2** included patients who were expected to improve in ADL score so that they finished with an ADL score of 81 to 95. If the patient started with a score between 81 and 95 and was not expected to change, he would be predicted for placement in Group 4 below.

**Group 3** included patients who were expected to improve in ADL score, finally attaining an ADL score of 41 to 60.

**Group 4** included patients who were expected to show no significant change in ADL score.

**Group 5** included patients who were expected to deteriorate in ADL score. By definition, a patient with an ADL score of 20 or less could not deteriorate further.

**Chart 1: Twelve groups of patients by major diagnosis or disability causing referral to department of physical medicine and rehabilitation. Means and standard deviations of age, ADL and MSCL scores. Predicted outcome of treatment, actual outcome, and final disposition of patients.**

		IA1C	IA4	ID1	IIA	IIA6	IIA7	IIA8	IIB1	IIB2	IIB3	IVI	IVM
NUMBER OF CASES		9	11	9	15	13	8	9	21	40	20	18	87
mean + standard deviation (age)		76± 9	74±12	65± 7	54± 9	53± 9	60± 8	60±16	69±12	68±13	77± 9	35±12	75±1
mean + standard deviation (initial ADL)		53±35	30±20	44±38	32±36	19±27	36±42	38±18	27±34	34±35	35±33	73±24	29±3
mean + standard deviation (initial MSCL)		24±16	23±10	29±15	20±15	33±14	27±10	37± 7	16±10	10±11	25±15	22±14	11±1
mean + standard deviation (final ADL)		55±37	33±31	45±39	25±28	13±20	34±45	36±23	27±12	29±35	40±35	54±39	29±2
SEX	Men		3	2	6	5	6	5	9	13	5	8	19
	Women		8	7	9	8	2	4	12	27	15	10	68
PREDICTED/  ACTUAL  GROUP	1	1/0	0/0	1/1	0/0	0/0	1/1	0/0	1/1	3/2	1/0	5/3	1/0
	2	1/1	0/0	1/0	0/0	0/0	1/0	1/0	1/1	1/0	1/1	0/0	4/0
	3	0/1	2/2	0/0	0/0	1/0	0/1	0/1	4/0	5/3	4/3	0/1	5/0
	4	7/7	9/9	7/7	15/14	12/11	6/5	8/7	15/18	30/31	14/15	6/4	75/
	5	0/0	0/0	0/1	0/1	0/2	0/1	0/1	0/1	1/4	0/1	7/10	2/
Disposition	Died	5	4	3	2	3	3	2	9	5	2	12	30
	Discharged	4	1	4	2	2	1	3	1	17	8	4	2-
	In Hospital	0	6	2	11	9	2	6	6	18	10	2	3



## Results

Chart 1 shows the results of this study. The top line gives the major diagnosis or condition for which the patient was being treated in the department of physical medicine and rehabilitation: hip fracture (IA1c), lower extremity amputation (IA4), rheumatoid arthritis (ID1), miscellaneous chronic neurological diseases (IIA), disseminated sclerosis (IIA6), quadriplegia (IIA7), paraplegia (IIA8), brain stem vascular accidents (IIB1), right hemiplegia (IIB2), left hemiplegia (IIB3), neoplasms (IVI), and chronic brain syndrome of unexplained etiology (IVM).

## Age

Patients with neoplasms were strikingly younger than those in any other group. Those with chronic neurological diseases and quadriplegia were younger than those with paraplegia. The patients with left hemiplegia were significantly older than those with right hemiplegia. We cannot explain this finding, as it has not been true in other series. The oldest age groups contained those patients with hip fracture, lower extremity amputations, left hemiplegia, and "chronic brain syndrome".

**Initial ADL:** Patients with neoplasms had the highest ADL scores; those with quadriplegia, the lowest. There was little difference between the right and left hemiplegics on initial ADL score.

**Initial MSCL:** The maximal value for this test is 50 and the highest scores were recorded by the paraplegic patients. Patients with right hemiplegia performed poorest and their scores were significantly lower than those with a left hemiplegia.

**Final ADL:** Changes between initial and final mean ADL scores were not very great. This is consistent with deterioration in the score of some patients balancing improvement in the score of other patients. It is of interest, however, that patients with left hemiplegia appeared to do much better than those with right hemiplegia.

**Predicted final ADL vs actual final ADL:** The

groups are small except in prediction Group IV (unchanged ADL score). In this group the predictions were very well substantiated when the patient was reevaluated by ADL score at discharge or after one year. The group which appeared to be hardest to predict was that with the diagnosis of "chronic brain syndrome".

However, the great majority of these patients were not expected to change greatly in their ADL score when first seen.

## Discussion

In a previous study,<sup>5</sup> we applied the above method of evaluation and prediction to inpatients seen in a department of physical medicine and rehabilitation in an acute general hospital. The major conclusions were that it was difficult to predict how the patient would do under treatment. The predictions tended to be optimistic. The lesson learned was that an optimistic prediction is justified if one wishes to accomplish the highest function activity in the largest number of patients.

The present study was performed on patients who had generally been ill for a prolonged period. It demonstrates that predictions of how the patient will do under therapy in a department of physical medicine and rehabilitation is more accurately predictable in patients with chronic diseases, probably because most have reached a plateau of function because of the duration of their disability.

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## Baltimore City health department

# Baltimore's Health Highlights for 1970

The lowest infant death rate on record and the lowest birth rate since 1940 are two of the highlights in Baltimore's 1970 health record, according to a provisional report on the city's health released by Robert E. Farber, MD, Commissioner of Health for Baltimore City.

Births and deaths were down. But heart disease, cancer, strokes, and accidents continued as leading causes of death. Lung cancer deaths are at an all-time high in the city, and a sharp increase in home accidents has been noted.

Other significant public health events included:

1. Designation by the U.S. Public Health Service of the city's Rat Eradication Program as first among comparable cities in the country;

2. Selection by a joint three-agency national mental health group of the Baltimore Psychiatric Day Center as one of 12 models for replication among more than 265 in the country;

3. Expansion of the city's mental health program and the appointment of John B. De Hoff, MD, MPH, Deputy Commissioner, as chairman of a new Drug Abuse Task Force for Baltimore City designated by City Council President William Donald Schaefer;

4. Extension for another three years of the department's Alcoholism Counselor Training Program through a \$225,000 grant from the National Institute of Mental Health. Some 75 graduates are now counseling alcoholics and their families in a variety of locations. In 1970, the city's Alcoholism Center served about 800 new alcoholics and their families;

5. Expansion of the Health Aide Training Program to a six-month course of study and training including first aid and a high school equivalency examination. A total of 92 previously unemployed or underemployed residents are now working in health or related fields;

6. Major planning support to the Maryland Con-

sortium for the Health Sciences, Inc., a partnership of schools and colleges, hospitals, professional associations, and agencies to improve health manpower development. A health career lattice for Baltimore residents now extends from ninth grade through university level;

7. Further progress in dental care for the needy through a \$300,000 Model Cities grant for six mobile dental units and a \$400,000 supplementary grant for operation and maintenance. Target date for the mobile service is May 1, 1971. It is now conceivable that 100,000 of our most needy residents will be reached with comprehensive dental services;

8. Surveillance of some 7,000 animal bite cases by the newly appointed public health veterinarian and close observation of about 700 animals for rabies control. No case of human rabies has been reported since 1930. With bites by stray animals on the increase, greater attention must be paid to animal control measures in Baltimore. The veterinarian also visited slaughterhouses and meat processing plants to observe compliance with the new state meat inspection law and established and maintained liaison with veterinary practitioners and veterinary regulatory agencies in the area;

9. A record of 15 consecutive years in which no unpasteurized milk has been sold to the public—a result of daily inspections of milk plant operations;

10. Development of a Composite Air Pollution Index so that laymen will have a better idea of the quality of Baltimore's air. The index grades the air from 0 to 100 in increments of 25 from "Clean Air" to "Very Heavy Pollution". An Air Pollution Register of polluters and a Motor Vehicles Exhaust Emissions Surveillance Program was also inaugurated;

11. Election of Mrs. Eleanor M. Snyder, Chief of Nutrition, to the post of chairman of the food and nutrition section of the American Public Health Association;



12. Sponsorship and support of an informed association of metropolitan hospital emergency department physicians, nurses, and administrators (MED-HEADS) who meet monthly to improve emergency services in the Baltimore area.

Additional information on the state of the city's health and City Health Department's programs may be found in the January-February issue of *Baltimore Health News* entitled "Guarding the Health of Baltimore—1970".

#### Provisional Report of Vital Statistics for 1970

	Cases		Resident Deaths	
	1970	1969	1970	1969
<b>Total</b>	<b>16,851*</b>	<b>13,780*</b>	<b>11,373</b>	<b>11,484</b>
<b>REPORTABLE DISEASES</b>				
Chickenpox	463	285	0	0
Diarrhea and enteritis	12	8	8	8
Diphtheria	0	0	0	0
Dysentery	230	106	1	0
Encephalitis (acute infectious)	2	2	0	0
German measles	206	149	0	0
Hepatitis, infectious	285	267	6	8
Measles	735	77	1	0
Meningococcal infections	14	15	2	4
Mumps	665	283	0	0
Poliomyelitis (paralytic)	0	0	0	0
Salmonellosis	431	229	7	0
Smallpox	0	0	0	0
Streptococcal sore throat and scarlet fever	176	100	0	0
Tetanus	0	1	0	0
Tuberculosis (active)	490	500	92	76
Typhoid fever	3	1	0	0
Undulant fever	0	0	0	0
Venereal diseases				
Syphilis	1,460	1,742	11	12
Gonorrhea	11,412	9,629	0	0
Whooping cough	14	8	0	0
<b>OTHER CAUSES OF DEATH</b>				
Accidental causes			475	430
Home			192	150
Occupational			20	25
Motor vehicle			167	162
Other public			96	93
Cancer			2,067	1,980
Cerebrovascular disease			813	855
Cirrhosis of liver			350	351
Congenital malformations and diseases of early infancy			292	332
Diabetes mellitus			367	370
Heart disease			4,478	4,559
Homicide			232	231
Influenza			6	8
Nephritis and nephrosis			50	63
Pneumonia			314	356
Puerperal causes			7	8
Suicides			105	108
Other external causes			48	41
Other specified causes			1,641	1,684

\* Includes other reportable diseases: 253 cases in 1970 and 378 in 1969



## Provisional Figures, 1970

## Final Figures, 1969

	Recorded	Resident		Recorded	Resident	
		Number	Rate*		Number	Rate*
Births:	Total	23,634	16,111	17.9	25,134	16,325
	White	13,668	6,740	14.1	15,050	6,898
	Nonwhite	9,966	9,371	22.1	10,084	9,427
Deaths:	Total	12,897	11,373	12.6	13,206	11,484
	White	8,690	7,167	15.0	8,951	7,275
	Nonwhite	4,207	4,206	9.9	4,255	4,209
Infant	Total	562	404	25.1	598	445
Deaths:	White	273	137	20.3	291	157
	Nonwhite	289	267	28.5	307	288

\* Birth and death rates per 1,000 population, infant mortality rates per 1,000 live births

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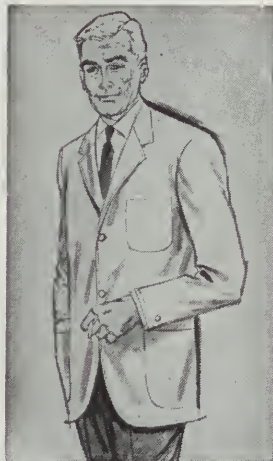
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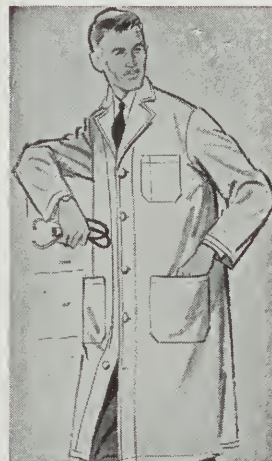
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## **tuberculosis**

# **Pulmonary Sarcoidosis: A Prospective Evaluation of Glucocorticoid Therapy**

**Data in this first controlled prospective study on the therapeutic effects of glucocorticoids on pulmonary dysfunction in sarcoidosis failed to yield any significant evidence that this therapy produces beneficial change in pulmonary function.**

The efficacy of glucocorticoid therapy in the treatment of pulmonary dysfunction in sarcoidosis is still questionable despite numerous reports detailing its use.

It has been suggested that to be effective, adrenal corticoids should be given early on the theory that, if administered during the acute phase of illness, they may reduce inflammatory reaction and thereby prevent or at least curtail fibrosis.

Although amelioration of symptoms and improvement in chest roentgenographic abnormalities have been confirmed, pulmonary functional changes have been variable. However, previous studies of pulmonary function have been retrospective and often lacked suitable controls.

### **Prospective Controlled Study**

This study of 25 patients with proven sarcoidosis and pulmonary dysfunction was undertaken four years ago to pursue a prospective controlled investigation—with the results available in one to two

years—on the effects of glucocorticoid therapy on pulmonary function in early sarcoidosis.

The average age of the 20 men and five women in the study was 26. Duration of illness was determined to be less than one year for 21 patients, less than two years for three patients, and less than three years for one patient.

The diagnosis of sarcoidosis was based on the presence of noncaseating granulomas in either lung, lymph node, or Kveim test biopsy, together with clinical characteristics of sarcoidosis and the exclusion of other diseases. Fifteen patients had noncaseating granulomas shown on one biopsy (ten lung, and five scalene node). In the remaining ten, noncaseating granulomas were found at two or more sites.

### **Pulmonary Dysfunction**

The only significant pulmonary function abnormalities found were a decreased lung diffusion capacity ( $DL_{CO}$ ), abnormal, arterial oxygen tension ( $Pao_2$ ), decreased total lung capacity (TLC), or forced vital capacity (FVC), or all four.

Criteria for inclusion in the study were an abnormal  $DL_{CO}$  ( $DL_{CO} > 2$  standard deviations (SD) beyond normal) an arterial  $PO_2$  of less than 80 mm

*Lt. Col. Robert L. Young, USAF, MC, FACP; Maj. Lionel E. Harkleroad, USAF, BSC; Maj. Robert E. Lordon, USAF, MC, and John G. Weg, MD, FACP, Annals of Internal Medicine, August 1970 (Vol. 73, No. 2).*



Hg at rest or after exercise. (Ten patients on glucocorticoid therapy with normal function studies were followed serially but not considered for the treatment protocol.)

Presence of any concomitant disease that could affect pulmonary function excluded a patient from the protocol as did previous glucocorticoid therapy.

Patients meeting the study criteria were assigned to a control or treatment group on an alternate basis: 12 patients to the control group and 13 to the treatment group.

Treatment consisted of 15 mg of prednisone four times a day for one month and 5 mg four times a day for at least an additional five months. Isoniazid chemoprophylaxis was not given. To date, no patient in the treatment protocol has developed tuberculosis.

All patients were evaluated between one and two years after entering the protocol. In addition, 19 were evaluated six months after entering the study; seven, at one to two months. There was no significant change in the pulmonary function studies at one to two months, six months, or at the end of one to two years in either group.

#### Study Results

Prospective alternate-case treatment of patients with sarcoidosis showed no beneficial effect of prednisone on the pulmonary function abnormalities studied. Although the group studied was not large, the treated and untreated patients were initially similar in every value measured. They had disease of relatively short duration and showed predominantly inflammatory changes on percutaneous needle lung biopsy. Thus, theoretically, they were the best possible candidates for steroid therapy. The dose of prednisone used was high enough and of sufficient duration to cause facial changes consistent with Cushing's syndrome in every patient. In general, the pulmonary function values remained stable in both the treated and untreated groups.

Although an occasional favorable response was noted, it was either so slight or occurred so infrequently that it did not affect the overall results

in the treated group when compared with the untreated control group. Individual evaluation of each case did not show any dramatic improvement in a treated patient which was not matched by similar changes in an untreated patient, nor was any deterioration of pulmonary function observed when glucocorticoid therapy was discontinued.

One treated patient who maintained a relatively stable course for six months deteriorated progressively thereafter in spite of continued prednisone therapy. Previous reports of such deterioration after glucocorticoid therapy has been discontinued may have represented the natural course of the disease and not an effect from the steroids.

In earlier studies of small numbers of patients whose pulmonary function was evaluated, generally only the "sickest" patients were treated with steroids. Beneficial effects from this therapy have been confined largely to changes in vital capacity or involved a single case, or studies have been retrospective or with very brief follow-up, or all three.

In the present series, the patients with the more severe functional abnormalities were not found to be any more responsive to therapy than those with milder defects. Moreover, improvement in some control patients was comparable to that of patients who improved while taking glucocorticoids.

The combined experience from the literature indicates that when glucocorticoids are given to severely ill patients, symptomatic and roentgenographic improvements may occur.

It should be noted that the information in this study does not pertain to the treatment of extrapulmonary sarcoidosis. The major objective of this study was to define the effect of adequate glucocorticoid therapy on pulmonary function in patients with "early" sarcoidosis.

If steroids are to be used in treating pulmonary sarcoidosis, it should be with the realization that while symptoms and chest roentgenograms may improve, significant permanent improvement in pulmonary function or alteration in the ultimate course of the disease by early steroid therapy has not been documented.

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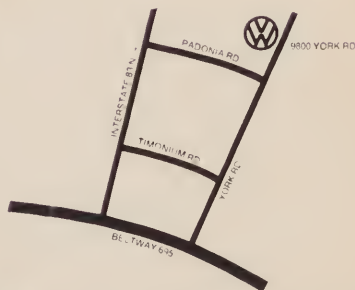
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sible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal

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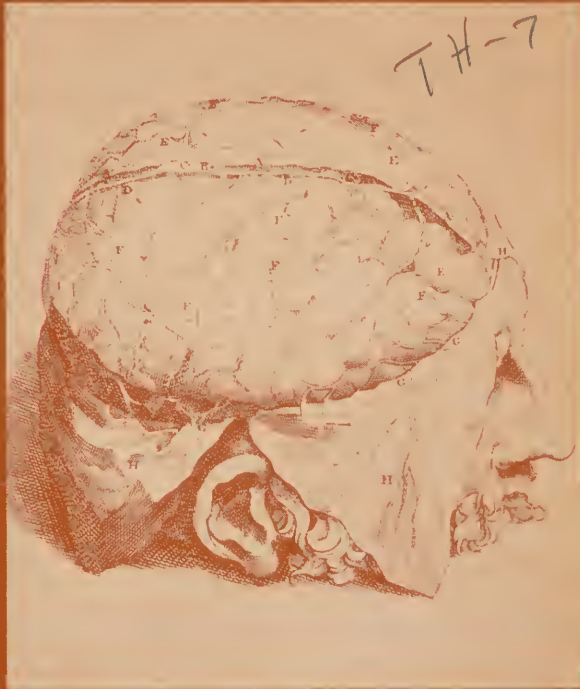
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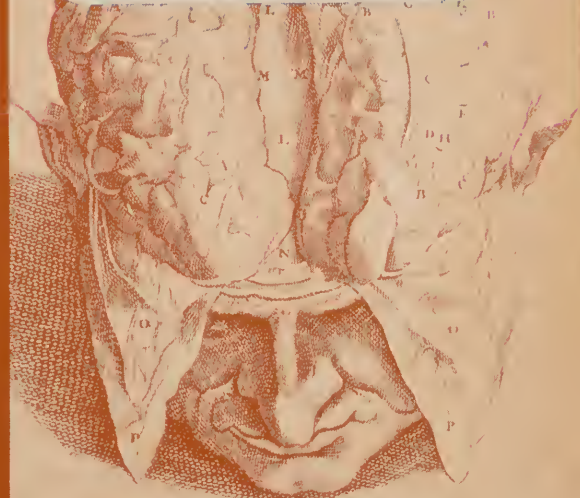
VOLUME 20 NUMBER 4

APRIL 1971

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# IF MORE MEN CRIED



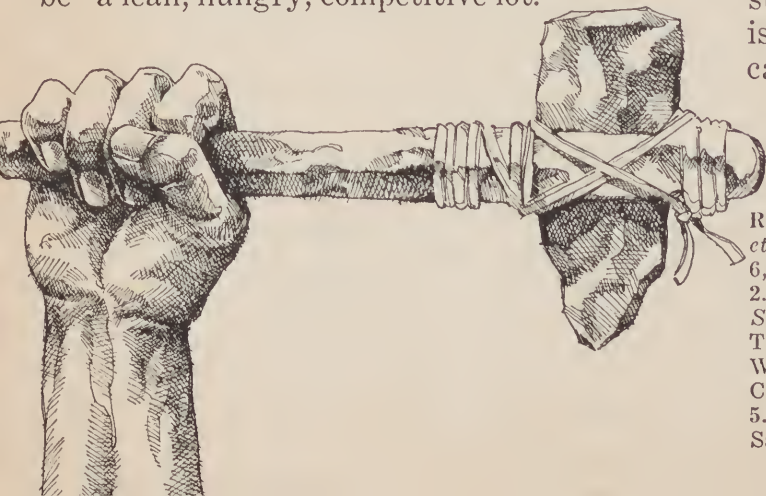
At least seventy-five out of one hundred adults with duodenal ulcers are men.<sup>1</sup>

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."<sup>2</sup>

## Hypersecretion—an atavistic response.

Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."<sup>2</sup>

**By chance? A lean, hungry lot.** Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."<sup>3</sup>



**Big boys don't cry.** If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.<sup>4</sup> Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.



## Take away stress, you can take away symptoms.

There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez<sup>5</sup> observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

**The rest cure vs. the two-way action of Librax.<sup>®</sup>** For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that com-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M., et al. (eds.): *Harrison's Principles of Internal Medicine*, ed. 6, New York, McGraw-Hill Book Company, 1970, p. 1444. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 163. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.



**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, over-sedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

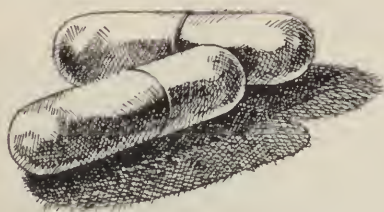
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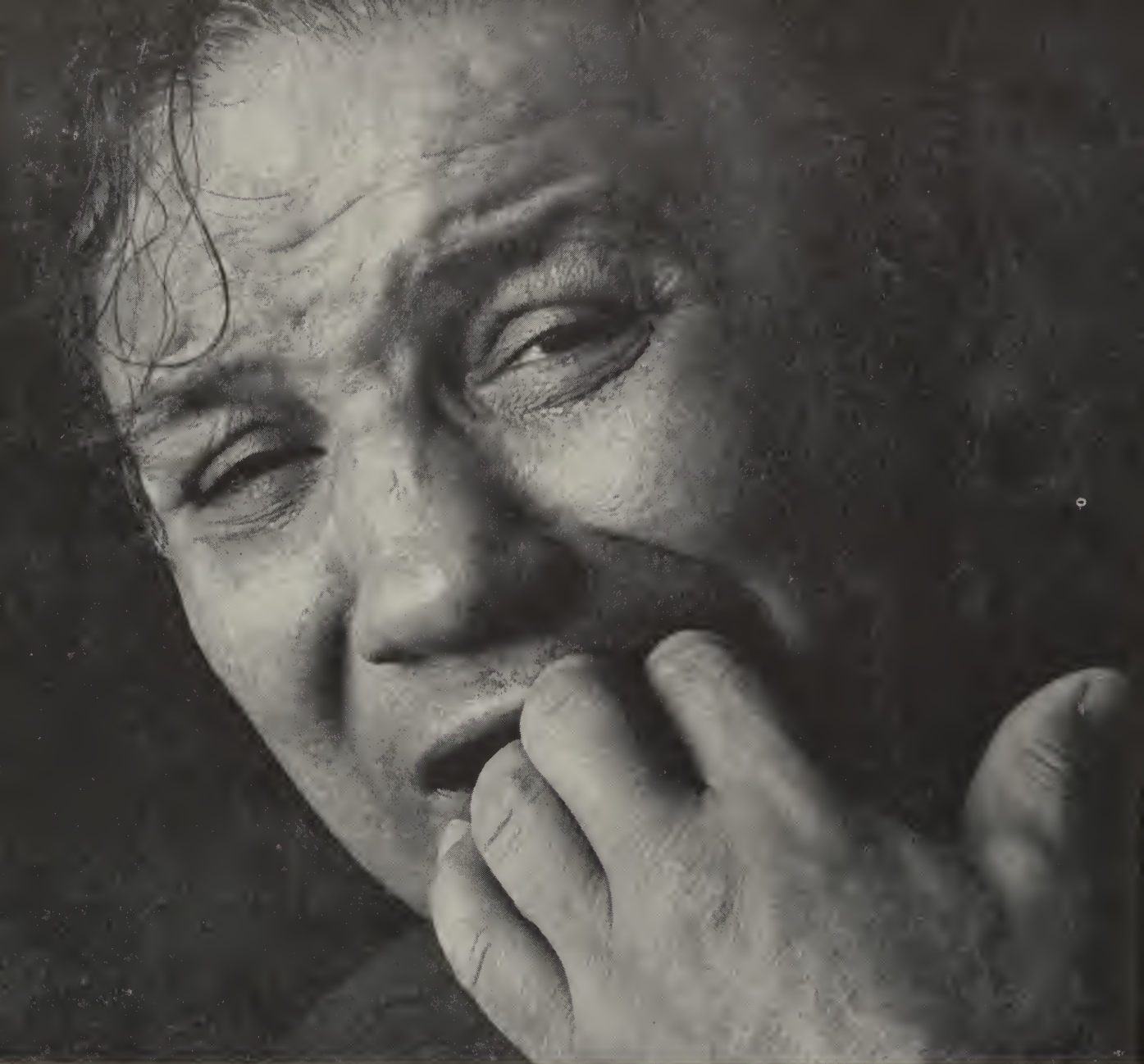
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# Doctors take note...

**APRIL 15-16, 1971**

**AMERICAN SOCIAL HEALTH ASSOCIATION/PFIZER LABORATORIES DIVISION OF PFIZER, INC.**

International Venereal Disease Symposium: Stouffer's Riverfront Inn, 200 South Fourth Street, St. Louis, Missouri 63102. The program will consist of a series of presentations on the first day, and six workshop sessions the second day. For further information, write: J. E. McLoughlin, Hill and Knowlton, Inc., 150 East 42nd Street, New York, New York 10017.

**APRIL 15-18, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS**

Fourth National Sex Institute of the American Association of Sex Educators and Counselors: St. Louis, Missouri. Contact: Dr. Patricia Schiller, Executive Director, AASEC, 815 15th Street, NW, Washington, D. C. 20005.

**APRIL 16-18, 1971**

**AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE/DEPARTMENT OF HEALTH, EDUCATION AND WELFARE**

Regional Conference on the Workings of Foundations for Medical Care: Rochester, New York. The meeting will contain a peer-review workshop, and will also deal with administration and basic Foundation functions. Registration fee is \$150 per association. For additional information, write: MATS, P. O. Box 230, Stockton, California 95201.

**APRIL 18, 1971**

**AMERICAN ACADEMY OF PEDIATRICS, COMMITTEE ON PEDIATRIC MANPOWER/AMERICAN NURSES' ASSOCIATION/AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS**

Conference—Who Will Take Care of Tomorrow's Children?: Chase-Park Plaza Hotel, St. Louis, Missouri. The program was developed by pediatricians, nurses, and other allied health personnel and is designed to explore various manpower problems and solutions relevant to the delivery of child health care. Write: Director, Office of Allied Health Manpower, American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

**APRIL 19-21, 1971**

**AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Clinical Pharmacology, With Emphasis on Newer Drugs: University of Michigan Medical Center, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan. For information, write: Registrar, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

**APRIL 19-21, 1971**

**AMERICAN DIABETES ASSOCIATION/UNIVERSITY OF CALIFORNIA, SAN FRANCISCO**

Third Allied Health Postgraduate Course in Diabetes: San Francisco, California. The course will include workshops, panel discussions, and morning and afternoon sessions. Fee: \$50 for members of the association; \$65 for nonmembers. Write: American Diabetes Association, Inc., 18 East 48th St., New York, N. Y. 10017.

**APRIL 1971**



**APRIL 19-21, 1971**

**AMERICAN ACADEMY OF PEDIATRICS**

Annual Spring Session: Chase-Park Plaza Hotel, St. Louis, Missouri. The session will cover subjects such as the pediatrician's role in ecology, intensive care units for high-risk infants, concepts and relationship to the community, and pediatric evaluation and management of learning the behavioral disorders. For information, write: American Academy of Pediatrics, Department of Public Information, 1801 Hinman Avenue, Evanston, Illinois 60204.

**APRIL 19-22, 1971**

**INDUSTRIAL MEDICAL ASSOCIATION/AMERICAN ASSOCIATION OF INDUSTRIAL NURSES**

American Industrial Health Conference: Atlanta, Georgia. Contact: Doris Flourney, 150 North Wacker Drive, Chicago, Ill. 60606.

**APRIL 21-23, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Advanced Seminar on Conception Control for Professionals: New York city. Contact: Livia S. Wan, MD, Director of the Family Planning Division, New York University School of Medicine, 550 First Avenue, New York, New York 10016.

**APRIL 22-24, 1971**

**AMERICAN COLLEGE OF CHEST PHYSICIANS**

Postgraduate Program—Interstitial Pneumonia: Acute and Chronic: Page and William Black Postgraduate School of Medicine of the City University of New York, New York city. Contact: American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

**APRIL 23-24, 1971**

**AMERICAN GERIATRICS SOCIETY**

28th Annual Meeting: Ambassador Hotel, Chicago, Illinois. Individual scientific research reports will discuss therapy for parkinsonism, coronary artery surgery, chronic peptic ulcer disease, and the prevention of atherosclerosis. Write: Edward Henderson, MD, Executive Director, American Geriatrics Society, 10 Columbus Circle, New York, N. Y. 10019.

**APRIL 23-25, 1971**

**AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE/DEPARTMENT OF HEALTH, EDUCATION AND WELFARE**

Regional Conference: Charleston, South Carolina. Included will be a peer-review workshop, a session on administration, and discussion of basic Foundation structures. Registration fee: \$150 per association. Write: MATS, P. O. Box 230, Stockton, California 95201.

**APRIL 25, 1971**

**SUBCOMMITTEE ON AGING, COMMITTEE ON COMMUNITY HEALTH CARE, COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION**

Conference—Long-Term Care—Management of the Patient in the Long-Term Care Facility: Drake Hotel, Chicago, Illinois. For additional information, write: American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

*(Continued on page 18)*





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USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

**Precautions:** It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

**Adverse Reactions:** Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established. **Dosage and Administration:** Adults—1 to 2 tablets 3 to 4 times daily.

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# executive director's newsletter

April, 1971

## LEASING PLAN FOR AUTOS

The Faculty has finally completed arrangements for leasing automobiles to its members. As of April 1, 1971, vehicle equipment leasing services, at advantageous rates, will be available to all members. Literature outlining the program is in the mail.

The program will be administered by Public Service Driv-Ur-Self System, Inc., a Baltimore based firm with offices located at the Village of Cross Keys.

## REFERENCE COMMITTEE MEETING

The Reference Committee has scheduled an open meeting to discuss the following resolutions submitted for consideration at the Annual Meeting on Friday, May 14, 1971 in the Faculty building:

8 PM, THURSDAY, APRIL 15, 1971

Resolution 1A/71: (Submitted by Allegany County)

Employment of a Qualified Negotiator to Deal With Third Party Payment Mechanisms Under Policy Direction of an Appropriate (Faculty) Committee.

Resolution 2A/71: (Submitted by Baltimore city)

Requesting the Medical and Chirurgical Faculty to (1) Urge Blue Cross to Formulate Plans for Home Health Services for Its Subscribers, (2) Urge Legislators, Local, State and Federal, to Hold Open Hearings in Maryland to Investigate Needs and Find Methods for Financing Such Services.

Resolution 3A/71: (Submitted by Carroll County)

Failure of the Medical Administration to support the Family Practice Program, University of Maryland School of Medicine.

## LAST ISSUE OF ASSEMBLYMAN

Because of the press of activity during the 1971 General Assembly, only an initial and final copy of The Assemblyman has been issued.

The last issue for 1971 will be in the mail during the next week or so. It contains a summary of all bills introduced, and their status, and a summary of those more important activities handled during this session.



BOARD OF  
MEDICAL EXAMINERS  
RULES AND  
REGULATIONS

Notice is hereby given that Board of Medical Examiners is revising its rules and regulations covering reciprocity and licensure.

Any communications in connection with such changes should be addressed to:

Board of Medical Examiners  
1211 Cathedral Street  
Baltimore, Maryland 21201

SPECIALTY  
SOCIETY  
VISITS

Visits have now been completed to these statewide specialty groups: the Maryland Radiological Society and the Maryland Psychiatric Society.

MALPRACTICE  
STUDY

Preliminary findings in the study of ten-year incidence of professional liability in Maryland indicate that almost equal numbers of suits have been filed against board-certified and non board-certified physicians.

The findings also indicate that suits are most often filed against general surgeons, followed by obstetricians and gynecologists, general practitioners, and anesthesiologists.

ANNUAL  
MEETING

Annual Meeting dates of May 12, 13, and 14, should be noted in your schedule. Hotel reservations may be made at the Hilton Hotel, nearby the Civic Center, where all the activities (except the Presidential Dinner) will take place.

The Presidential Dinner, Thursday, May 13, will be held at the Blue Crest North.

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# 173rd ANNUAL MEETING PROGRAM

## MEDICAL AND CHIRURGICAL

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### WEDNESDAY, MAY 12

9:30 AM—Meeting of the House of Delegates

2:00 PM—*Changing Attitudes and Practices Concerning Abortion: A Sociomedical Revolution*

Alan F. Guttmacher, MD, President, Planned Parenthood-World Population, New York city

2:45 PM—Intermission

3:00 PM—*Replantation of Amputated Extremities: Present Status*

G. Rainey Williams, MD, Professor of Surgery, University of Oklahoma Medical Center

3:45 PM—*Acute Renal Failure*

George E. Schreiner, MD, Professor of Medicine, Georgetown University School of Medicine; and Director, Renal and Electrolyte Division, Georgetown University Hospital

6:00 PM—**Hospitality Night** for all members and their wives. Baltimore Hilton Hotel

8:15 PM—*Treatment of the Alcoholic and the Family*. A panel-symposium

Sponsored by the **Committee on Medicine and Religion**, Medical and Chirurgical Faculty, Martin L. Singewald, MD, Chairman

### THURSDAY, MAY 13

9:15 AM—*Viral Hepatitis*

Saul Krugman, MD, Professor and Chairman, Department of Pediatrics, New York University School of Medicine

10:00 AM—Intermission

10:15 AM—*Current Problems in Pediatrics: Operative and Nonoperative Management*. Medical and Surgical Pediatric Grand Rounds

Conducted by Marvin Cornblath, MD, and J. Alex Haller, Jr., MD, University of Maryland School of Medicine and The Johns Hopkins University School of Medicine

12:00 NOON—Election of Board of Medical Examiners

12:30 PM—**ROUND TABLE LUNCHEON**. Baltimore Civic Center

2:15 PM—*Pediatric Surgery: A Century of Progress*

Lawrence K. Pickett, MD, Professor of Surgery and Pediatrics, Yale University School of Medicine

3:00 PM—Intermission

3:15 PM—*Current Problems in Pediatrics: Operative and Nonoperative Management*. Medical and Surgical Pediatric Grand Rounds. *Continued*

Conducted by Marvin Cornblath, MD, and J. Alex Haller, Jr., MD, University of Maryland School of Medicine and The Johns Hopkins University School of Medicine

6:15 PM—**PRESIDENTIAL RECEPTION AND BANQUET**. Music and dancing. Blue Crest North



# NEW DIMENSIONS IN MEDICINE

**MAY 12, 13, 14, 1971**

## UNLESS OTHERWISE INDICATED

### FRIDAY, MAY 14

**9:15 AM**—*"Sweet Are the Uses . . ."*

**Nicholas J. Pisacano, MD**, Secretary of the American Board of Family Practice, Inc.;  
and Chairman of Continuing Education, Associate Professor of Medicine, and  
Director of the Family Practice Program, University of Kentucky Medical Center

**10:00 AM**—Intermission

**10:15 AM**—*What the Law Requires in Physician-Patient Relationships and in Continuing  
Medical Education*

**Neil L. Chayet, LLB**, Boston

**11:00 AM**—*Self-Assessment as an Educational Tool*

**Edward C. Rosenow, Jr., MD**, Executive Vice President, American College of Phy-  
sicians, Philadelphia

**2:00 PM**—Meeting of House of Delegates. Faculty building

\* \* \* \* \*

### HEALTH EVALUATION TESTS—BALTIMORE CIVIC CENTER

This ever-popular benefit of membership in the Medical and Chirurgical Faculty will again be  
available for physicians at the Baltimore Civic Center during the three days of the Annual  
Meeting.

\* \* \* \* \*

### ART AND HOBBY EXHIBIT—BALTIMORE CIVIC CENTER

An opportunity is offered for physicians, their wives, and families to put their artistic talents  
on display. *See page 35 for the application form.*

\* \* \* \* \*

### SCIENTIFIC AND TECHNICAL EXHIBITS—BALTIMORE CIVIC CENTER

Wednesday, Thursday, Friday

Intermissions are provided to visit these exhibits. Get the most from the Annual Meeting—SEE  
THE EXHIBITS! *See page 24 for a list of Technical Exhibitors.*

\* \* \* \* \*

**SUPPORT YOUR MEDICAL SOCIETY**


**ATTEND THE MEETING**

**MAY 12, 13, 14, 1971**

**BALTIMORE CIVIC CENTER**

**Arlie R. Mansberger, Jr., MD**, Chairman  
Committee on Program and Arrangements





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# Book Reviews

**BECKER-SHAFFER'S DIAGNOSIS AND THERAPY OF THE GLAUCOMAS**, Allan E. Kolker, MD, and John Hetherington, Jr., MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

The first edition of this publication appeared in 1961; the current issue marks the second revision. There have been significant changes since the second edition appeared five years ago. While many of the chapters contain updated data, there are new sections including one on the microsurgery of the outflow channels, ab externo trabeculotomy, and trabeculectomy, both of which should be particularly interesting to readers.

Another new feature is that portions of several chapters have been devoted to problems for laboratory and clinical research. All in all, this new edition is well worth adding to any physician's library.

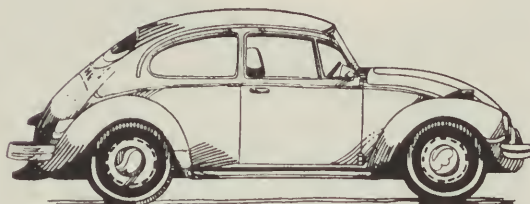
**DOCTORS IN HOSPITALS**, Milton I. Roemer, MD, and Jay W. Friedman; The Johns Hopkins Press, Baltimore, Maryland, 1971.

Contrary to what the title might imply, this is not a book deploring the activities of physicians in hospitals. Rather, it is directed to professionals and discusses the organizational patterns by which physicians work in general hospitals and relates these patterns to hospital performance.

The authors suggest that the future trend will be toward greater medical-staff structuring in all hospitals, coupled with increased control of hospital costs, improved medical care, and more regional planning of health services.

This volume should prove valuable to those who are involved in these areas; and indeed, for all physicians as well.

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**NOTE:** Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

**Contraindications:** Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

**Warnings:** May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

**Precautions:** When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

**Adverse Reactions:** *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

**How Supplied:** Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

For more detailed information, consult your MSD representative or see the *Direction Circular*. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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## Doctors Take Note . . .

*(Continued from page 6)*

**APRIL 26-30, 1971**

### **AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Alcoholism and Chronic Liver Disease: Auditorium, Personnel Building, Lemuel Shattuck Hospital, Boston, Massachusetts. The course will include question and answer sessions, actual cases, and small-group discussions. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

**APRIL 29-30, MAY 1, 1971**

### **AMERICAN HEART ASSOCIATION/HEART ASSOCIATION OF MARYLAND**

Three Days of Cardiology—Three Crucial Topics in Cardiology: Jack Masur Auditorium, Clinical Center, National Institutes of Health, Bethesda, Maryland. The session on April 30 will be held in the Thomas B. Turner Auditorium of The Johns Hopkins University. Contact: Heart Association of Maryland, 415 N. Charles St., Balto., Md. 21201.

**APRIL 30-MAY 20, 1971**

### **ALBANY MEDICAL COLLEGE OF UNION UNIVERSITY**

Spring Postgraduate Medical Seminar **Cruise to the Mediterranean**: Contact: William P. Nelson, III, MD, Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

**MAY 1, 1971**

### **NATIONAL GUILD OF CATHOLIC PSYCHIATRISTS**

22nd Annual Scientific Meeting: Washington Retreat House, 4000 Harewood Road, NE, Washington, D. C. The symposium presentations will cover up-to-date philosophical, psychological, moral, and socioeconomic problems. For further information, contact: Donato J. Alamprese, MD, FAPA, Program Chairman, St. Agnes Medical Center, Suite 306, Wilkens and Pine Heights Aves., Baltimore, Md. 21229.

**MAY 1-6, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS**

Postgraduate Courses and 19th Annual Clinical Meeting: Civic Auditorium and Brooks Hall, San Francisco, California. The program will develop three themes: perinatology, pelvic infections, and diseases of the vulva. For further information, write: Donald F. Richardson, 79 West Monroe Street, Chicago, Illinois 60603.

**MAY 1-8, 1971**

### **NATIONAL ASSOCIATION OF UNDERWATER INSTRUCTORS**

First Diving Medicine Course for Physicians: Underwater Explorers Club, Freeport, Grand Bahama. The primary objective of the program is to acquaint much of the medical population with the problems of underwater physiology and therapy for diving and diving-related injuries. Write: NAUI Headquarters, 22809 Barton Road, Colton, California 92324.

**MAY 7, 1971**

### **NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE**

Spring Meeting: Schenectady, New York. Representatives of government and industry will discuss the problem of solid waste. Contact: New York State Action for Clean Air Committee, 105 East 22nd Street, New York, N.Y. 10010.

*(Continued on page 28)*





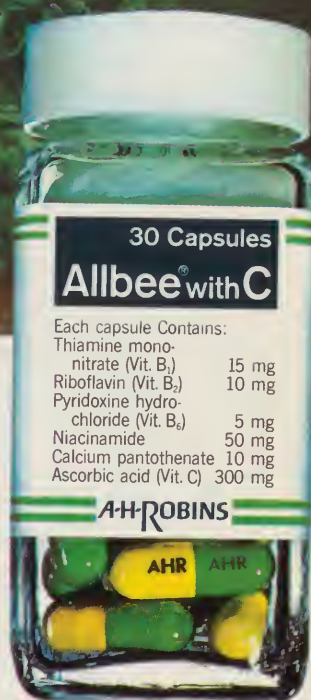
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# THE MONTH IN WASHINGTON

**The American Medical Association's 1971 Medicrodit national health insurance program was introduced in both chambers of the congress with more than 100 Democratic and Republican sponsors.**

The three chief sponsors again were Sen. Clifford Hansen (R.-Wyo.) and Reps. Joel T. Broyhill (R.-Va.) and Richard Fulton (D.-Tenn.). They and Dr. Russell B. Roth, speaker of the AMA House of Delegates, held a joint news conference on capitol hill in connection with introduction of the legislation (H.R. 4960 and S. 987).

There are two major differences between this Medicrodit legislation and the bill introduced last year. Catastrophic coverage has been added, and the peer review provision has been dropped because Congress is expected to approve such a program before considering national health insurance.

Medicrodit would:

- (1) Pay the full cost of health insurance for those too poor to buy their own.
- (2) Help those who can afford to pay a part of their health insurance premium. The less they can afford to pay, the

more the government would help out.

- (3) See to it that no American would have to bankrupt himself because of a long-lasting, catastrophic illness.

The government would pay all of the premium for low-income beneficiaries—an individual and his dependents without any income tax liability. For others, the government would provide scaled participation ranging between 97.5% and 10%, favoring lower-income persons, in the payment of premiums for basic coverage. It would pay the premium for catastrophic expense coverage in full, but there would be a "financial corridor" based on income before such coverage would begin.

A beneficiary eligible for full payment of premium by the federal government would be entitled to a certificate acceptable by carriers for health-care insurance for himself and his dependents. Eligible beneficiaries with whom the government would be sharing the cost of premium could elect between a credit against income tax or a certificate.

To participate in the Medicrodit program, a carrier would have to qualify under state law, provide certain basic coverage, make coverage available without preexisting health conditions, and guarantee annual renewal.

A qualified policy would offer comprehensive insurance against the ordinary and catastrophic expenses of illness. Basic benefits in a 12-month policy period would include 60 days of inpatient care in a hospital or 120 days in an extended-care facility. Other basic benefits would provide emergency and outpatient services and all medical services provided by doctors of medicine or osteopathy. The catastrophic expense protection would pay incurred expenses for benefits in excess of the basic

coverage, including hospital, extended-care facility, inpatient drugs, blood, prosthetic appliances, and other specified services.

Under the basic coverage, there would be a deductible of \$50 per hospital stay, and 20% coinsurance of the first \$500 of medical expense and on the first \$500 of emergency or outpatient expenses. Under the catastrophic illness provisions, the amount of the "financial corridor" would be based on taxable income: 10% on the first \$4,000, 15% on the next \$3,000, and 20% thereafter.

A health insurance advisory board of 11 members, a majority of whom shall be practicing physicians, and including the Secretary of Health, Education and Welfare and the Commissioner of Internal Revenue, would be appointed by the President with Senate consent. The board would establish minimum qualifications for carriers and, in consultation with carriers, providers and consumers, would develop programs designed to maintain the quality of health care and the effective use of available financial resources, health manpower, and facilities.

At the news conference, Dr. Roth said:

"Medicrodit offers four important benefits.

"It protects families and individuals from the financial catastrophe that can result from illnesses requiring protracted care.

"It enables people to receive **federal assistance** for health and medical care.

"It offers an individual or a head of a family, no matter what his income, the opportunity to select from among **private** medical plans the one best suited to his needs. If he does not like one plan, he can try another. In effect, Medicrodit says to everyone, 'Here's some federal assistance. Take it and use it for the sort of health care you want.'



"And Medigredit provides these benefits at a cost estimated at \$14.5 billion for the first year—considerably lower than nearly all other national health proposals. In other words, Medigredit will have a relatively modest impact on the tax increases necessary to finance any national health plan; it will thereby contribute less to the inflationary pressures which plague us all."

The three congressmen each keyed in on one of Medigredit's three main provisions.

"The current federal-state health program for the poor (medicaid) has been sick for a long time," Fulton said. "Some states offer good and adequate medical benefits, others offer substandard medical care and at least two states do not even participate in the program for their citizen poor. . . .

"The time has arrived to standardize the benefits in every state of the union guaranteeing to the poor of every state an adequate level of health care. The voucher system for the poor clearly states that the federal government will totally finance the cost of a basic, stated set of minimum benefits to the citizens of every state in the union."

"The tax credit feature of Medigredit is designed primarily to help low income families above the poverty level buy basic coverage health insurance," Broyhill said.

"By giving some tax credit to all taxpayers, the program will provide a strong incentive for all Americans to protect themselves with adequate health insurance.

"We believe that the tax credit provision is a much fairer and more equitable way of helping the near-poor and middle-income families pay for their health care than under medicaid. . . .

"This feature of Medigredit also will do away with the red tape and bureaucracy of the

means test required under medicaid."

"Medigredit gives every American family the opportunity to protect itself against the cost of a catastrophic illness," Hansen said. "No family would face the prospect of losing its savings or even its home because of medical bills. . . .

"The Senate Finance Committee last year voted 13 to 2—and I voted with the majority—in favor of a similar provision to protect all Americans against the cost of a catastrophic illness. I am confident that the congress will enact such legislation during this session."

It was pointed out that Medigredit deliberately was limited to financing of health care so that it would not be bogged down in details.

"Medigredit was designed to solve the most immediate and most obvious problem relating to medical and health care: making it possible for everyone to seek the attention he needs without regard to his ability to pay," the AMA said.

"However, through the AMA and many others with whom it is consulting, a package of companion programs is now in preparation to help the medical profession, its allies, the government and the people of the nation solve jointly many of the other health-oriented problems facing our nation.

"Those programs will deal with such longer-range problems as the quality of medical and health care, the most efficient utilization of medical and health personnel, the need for additional manpower, the distribution of manpower, the cost of providing care, and the need for custodial and home care for the elderly and disabled."

A week before introduction of the Medigredit legislation, President Nixon outlined the Administration's national health insurance program in a special message to Congress.

"Nineteen months ago, I said that America's medical system faced a 'massive crisis,'" he said. "Since that statement was made, that crisis has deepened. All of us must now join together in a common effort to meet this crisis—each doing his own part to more effectively mobilize the enormous potential of our health-care system."

The Administration program includes a National Health Insurance Standards Act which would require employers to provide basic health coverage for their employees. The minimum benefits would include hospital and physician care, full maternity care, well-baby care, laboratory expenses, and certain other expenses. There would be certain deductibles and coinsurance.

The minimum program would also provide at least \$50,000 in coverage for each family against the costs of catastrophic illness. Under this program employees could elect to be enrolled in a Health Maintenance Organization rather than receive the basic coverage through private carriers. The program would be paid for by the employer, 65% for the first 2½ years, 75% thereafter, and the employee, 35% and 25%. There would be no cost to the federal government.

A second Administration proposal would provide a Family Health Insurance Plan to replace medicaid for poor families. The program would be financed and administered by the federal government. It would provide health insurance to all poor families with children headed by self-employed or unemployed persons whose income is below a certain level, \$5,000 for a family of four. The program would pay all medical costs for families with income below a certain level, \$3,000 for a family of four. As income increases, the family would begin to pay part of the costs through a grad-



uated schedule of premiums, deductibles, and coinsurance.

In order to encourage states to use medicaid funds made available by this bill to supplement the basic program, the federal government would bear the costs of administering a consolidated federal-state benefit package. The program would become effective July 1, 1973 and would cost an estimated \$12.4 billion.

Walter C. Bornemeier, MD, President of the AMA, commended the Nixon Administration for developing "statesman-like" health proposals. He said that, "in overall philosophy and approach," there was "a great deal of common ground" between Medigap and the Administration program.

"The whole idea of removing the economic barriers to health

care for the poor and near-poor has been AMA policy for some time," Dr. Bornemeier said.

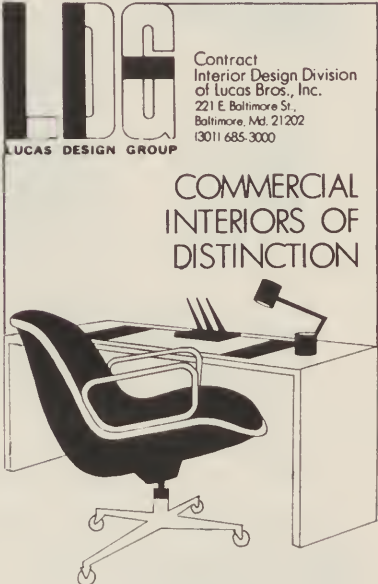
"On the matter of insurance against the catastrophic expenses of a long, protracted illness—a medical-health bill that can pauperize a family—we are again agreed in principle.

"The proposal for health insurance to be purchased on a mandatory basis mainly by employers for their employees is an intriguing one. . . .

"We are going to have to take a more detailed look at the proposals on health maintenance organizations (HMO's). Although the Nixon approach is an optional approach, both to physicians and to patients, we are not sure that HMO's represent real solutions to current medical problems. We feel they should be tried on a demonstra-

tion basis, and thoroughly researched—as should a number of other delivery methods."

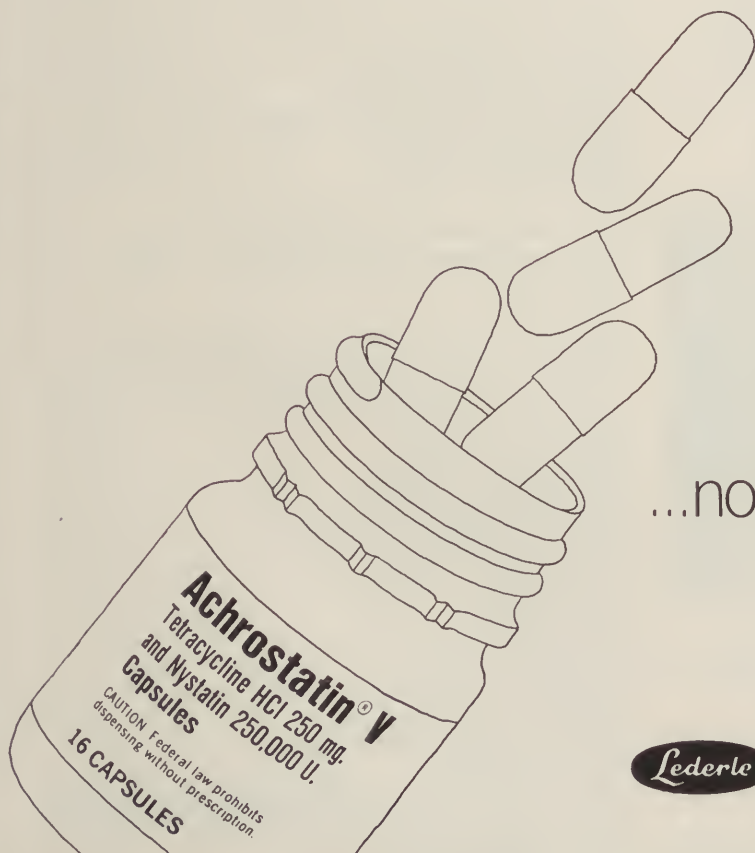
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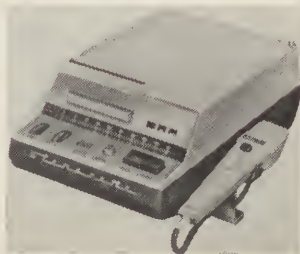
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## THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM of the MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING at the Baltimore Civic Center MAY 12, 13, 14, 1971 TECHNICAL EXHIBITORS (as of March 1971)

Ayerst Laboratories  
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Doctors Supply Company  
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Hoechst Pharmaceutical Company  
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Upjohn Co.  
Lakeside Laboratories, Inc.  
Lederle Laboratories  
Eli Lilly and Company  
Marion Laboratories, Inc.  
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Maryland Surgical Supply Company  
Medco Products Company  
Merck Sharp & Dohme  
Merrill Lynch, Pierce, Fenner & Smith, Inc.  
C. V. Mosby Company & Year Book  
Murray-Baumgartner Surgical Instrument Company  
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Skill Surgical  
Smith, Miller & Patch, Inc.  
E. R. Squibb & Sons, Inc.  
Symbionics, Incorporated  
Warner-Chilcott Laboratories  
Wills X-ray Supplies, Incorporated  
Wyeth Laboratories  
Geigy Pharmaceuticals and Hynson, Westcott & Dunning, Inc. are making a contribution, although they are unable to exhibit this year.





PAUL F. GUERIN, MD, CHAIRMAN  
Library and History Committee  
ELIZABETH SANFORD  
Librarian

## library

# The Cover

The three illustrations appearing on this month's cover are from the *Opera Omnia Anatomica et Chirurgica* of Andreas Vesalius (1514-1564). Published at Leyden in 1725, the work is edited by Herman Boerhaave (1668-1738) and his student, Bernhard Siegfried Albinus (1697-1770), two well-known figures in the history of medicine.

Although published 161 years after the death of Vesalius, the illustrations are well noted for their cautious preparation and beauty. The woodcuts of the *De Corporis Humani Fabrica* (1543 and 1555) and the *Epitome* are handsomely copied and engraved on copper and are maintained in the original size by Jan Wandelaar.

The original Vesalian drawings are attributed to John Stephen of Calcar. Little is known of his origin

but it is believed that the date of his birth was around 1499 and that he died before 1550.

It is interesting to note that John Stephen, a Fleming, found his way southward to Italy and became Titian's pupil. He assimilated and mastered the idiom of the south and of his teacher to a degree that can only be described as a remarkable achievement.

The drawings of John Stephen of Calcar combine scientifically exact representations of anatomy with the aesthetics of High Renaissance art. This manner of presenting anatomy as "living anatomy", dissected figures engaged in vitally animated behavior, began a trend that was to last for over a century.

Michael A. Murray  
Library Assistant

## New Journals (Continued)

Following up the listing of new journal subscriptions that appeared in the March issue, we will review several more titles that have been added to the library.

*Environmental Health Letter* is in its tenth volume; our first issue is dated March 1, 1971. This eight-page looseleaf publication, a semimonthly, is published by Gershon W. Fishbein, 1097 National Press Building, Washington, D.C., 20004. On April 8, the same publisher will begin a new semimonthly entitled *Occupational Health and Safety Letter*.

The EHL is particularly interested in legislation concerned with pollution of all types, the standards being set up, studies in progress, projects underway or planned, contracts, and key personalities in the environmental control effort. Since this is in loose-leaf format, it will not circulate.

*Infection and immunity*, a monthly publication of

the American Society of Microbiology, 4715 Cordell Avenue, Bethesda, Maryland, 20014, is related to environmental control through ecology, epidemiology, infection, and chemotherapy. Members of the society may receive the journal as part of their dues.

Whereas the *Environmental Health Letter* is a news sheet, this journal is the scientific publication, using adequate illustrations and very few ads.

\* \* \*

Next month, look for "Impressions of a Book Auction".

## Meetings

During the 173rd Annual Meeting of the Medical



and Chirurgical Faculty at the Civic Center in Baltimore, May 12, 13, 14, 1971, the library will display a sampling of books and library materials. Bring your complaints, requests, and suggestions to the Library booth and get acquainted with our services.

Baltimore Hospital Librarians Association, Broad-

view Apartments, Baltimore, Luncheon, 2 PM, May 20, 1971—Annual Business Meeting.

Special Libraries Association—April 22, 1971. Speaker: Dr. Edwin Olson, Faculty, School of Library and Information Services, University of Maryland, College Park, Md., Holiday Inn (Downtown), Baltimore. Time: 6:15 PM.

## NEW ACCESSIONS—BOOKS

(Arranged by subject)

### MEDICAL CARE—U.S.:

Maryland State Dept. of Health. Division of Medical Facilities Development.

**Licensed institutions:** nursing homes—extended care, intermediate care facilities . . . Baltimore, 1971. Ref. WX22 M3 1971.

U.S. President, 1968- (Richard M. Nixon)

**Full text of Nixon's health message to Congress:** February 18, 1971. Ref.WA.AA1 U6 1971.

Hospital Research and Educational Trust.

**Training and continuing education,** a handbook for health care institutions. Chicago, 1970. WX159 H6 1970.

### FORENSIC MEDICINE:

American Medical Association. Legal Research Department.

**The best of law and medicine, 1966-1968.** Chicago, 1968. RA1051 A5.

### GROUP PRACTICE:

American Association of Medical Clinics.

**Group practice:** guidelines to joining or forming a medical group. 2d ed. Chicago, 1970. Ref.W92 A5 1970.

### GYNECOLOGY AND OBSTETRICS:

Mayes, Mary

**Handbook of midwifery.** 7th ed. rev. by Vera Da Cruz. Baltimore, Williams & Wilkins, 1967. WQ160 M2 1967.

**The midwife in the United States;** report of a Macy conference. New York, Josiah Macy, Jr. Foundation, 1968. WQ160 M5 1968.

### NERVOUS SYSTEM:

Maryland State Medical Journal

**Rehabilitation of spinal cord injuries.** Baltimore, 1970. WL400 M3 1970.

### DRUG ADDICTION:

Harms, Ernest

**Drug addiction in youth.** Oxford, New York, Pergamon Press, 1965. International series of monographs on child psychiatry, v. 3. WM270 H2 1965.

### OPHTHALMOLOGY:

Patz, Arnall

**Protection of vision in children,** by Arnall Patz and Richard E. Hoover. With contributions by Ruth L. Gottesman and Robert M. Worthington. Springfield, Ill. Thomas, 1969. WW141 P3 1969.

### TRANSPLANTATION:

Caine, Roy Yorke

**A gift of life;** observations on organ transplantation. New York, Basic Books, 1970. WO610 C2 1970.

### HISTORY:

Ellenberger, Henri F.

**The discovery of the unconscious;** the history and evolution of dynamic psychiatry. New York, Basic Books, 1970. WM11 E5 1970.

Corner, George Washington

**Anatomist at large;** an autobiography and selected essays. Freeport, N.Y., Books for Libraries Press, 1969. WZ100 C6 1969.

Duffy, John

**Sword of pestilence;** the New Orleans yellow fever epidemic of 1853. Baton Rouge, Louisiana State University Press, 1966. WC530 D8 1966.

### UROLOGY:

Balough, Ferec

**Cancer of the prostate,** by F. Balough and Z. Szendroi. English text rev. by D. M. Wallace. 2d rev. ed. Academiai Kiado, Budapest, 1968. WJ752 B2 1968.

### MEDICINE:

Clarke, James

**Man is the prey;** an investigation into the motives and habits of man's natural enemies. London, Deutsch, 1969. WD400 C5 1969.

**The International handbook of medical science;** a concise guide to current practice and recent advances. Edited by David Horrobin and Alexander Gunn. New York, Putnam, 1970. WB100 I6 1970.

King, Ambrose J.

**Venereal diseases,** by Ambrose King and Claude Nicol. 2d ed. London, Bailliere, Tindall & Cassell, 1969. WC140 K5 1969.

Nicholson, Max

**The environmental revolution;** a guide for the new masters of the world. London, Hodder and Stoughton, 1970. HC55 N5 1970.

Paton, Alexander

**Liver disease.** London, Heinemann Medical, 1969. WI700 P3 1969.

Sharp, Clive L. E. H.

**Presymptomatic detection and early diagnosis;** a critical appraisal. Edited by C. L. E. H. Sharp and Harry Keen. Baltimore, Williams & Wilkins, 1968. WA100 S4 1968.



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## Doctors Take Note . . .

*(Continued from page 18)*

**MAY 10-13, 1971**

### **AMERICAN HEART ASSOCIATION**

Four Days of Cardiology—Advanced Electrocardiography: Grady Memorial Hospital, Atlanta, Georgia. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201.

**MAY 10-14, 1971**

### **AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Intensive Care Units: St. Vincent's Hospital and Medical Center, Cronin 10 Auditorium, 153 West 11th Street, New York, New York. Because of limited seating, the usual waiver of fee for residents, interns, and fellows does not apply to this program. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

**MAY 10-14, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Ultrasonography in Obstetrics and Gynecology: New York city. Contact: Department of Obstetrics and Gynecology, NY Medical College, 1249 Fifth Avenue, New York, New York 10029.

**MAY 13-15, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Gynecologic Endocrinology: Oklahoma City, Oklahoma. Subjects for discussion include amenorrhea, hirsutism, diabetes, thyroid disorders, including both basic physiology and clinical diagnosis and treatment. Contact: Warren M. Crosby, MD, Program Chairman, Department of Gynecology and Obstetrics, University of Oklahoma Medical Center, 800 Northeast Thirteenth Street, Oklahoma City, Oklahoma 73104.

**MAY 15-18, 1971**

### **MEDICAL SOCIETY OF NEW JERSEY**

205th Annual Meeting: Haddon Hall, Atlantic City, New Jersey. Contact: Medical Society of New Jersey, P. O. Box 904, Trenton, New Jersey 08605.

**MAY 17-19, 1971**

### **AMERICAN CANCER SOCIETY**

2nd National Conference on Breast Cancer: Century Plaza Hotel, Los Angeles, California. Contact: Esther Kelley, Professional Education, American Cancer Society, Inc., 219 East 42nd St., New York, N.Y. 10017.

**MAY 18-21, 1971**

### **AMERICAN PUBLIC HEALTH ASSOCIATION, SOUTHERN BRANCH/TENNESSEE PUBLIC HEALTH ASSOCIATION**

Joint Meeting—Universal Health Care: A Challenge to Public Health: Sheraton Peabody Hotel, Memphis, Tennessee. Contact: Mrs. Mildred Hicks, Information Supervisor, Memphis-Shelby County Health Department, 814 Jefferson Ave., Memphis, Tennessee 38105.

**MAY 19-21, 1971**

### **UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE**

Short Course—Topics in Internal Medicine: University of Florida, Gainesville, Florida. Contact: Mark V. Barrow, MD, Division of Cardiology, Department of Medicine, College of Medicine, University of Florida, Gainesville, Florida 32601.



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and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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Specific therapy for night leg cramps



# Help Desperately Needed

I could write a book about our recent visit to Atlantida Hospital in La Ceiba, Honduras.\* The 1970 president of this country said that his nation could be described as the four 70's: 70% illiterate, 70% illegitimate, 70% die of diseases easily treated, and 70% of the country is uninhabited. Most of the patients in the hospital were full of parasites, anemic, critically ill, and in nutritional failure.

I could not believe my eyes when I first approached this hospital—peeling paint, rusty corrugated roof, large windows with no screens. In reality, the hospital resembled an abandoned barn. Inside the building was equally depressing—rough concrete floors with central large floor drains used for spitting and vomiting. The beds were close together, were all different sizes, and the mattresses and sheets did not match. Basic hospital equipment was absent.

The hospital had 120 beds, and 100 to 200 outpatients were seen each day. Some of the patients waited two days in the sun, and many wanted to see "the American doctor", since they felt that he must be "the best". The hospital needs physicians to make ward rounds with their young physicians, review the cases, and help instruct them in the best possible care. This hospital has primitive medical equipment—and very little of that. So, they must make do with their ingenious methods to improvise.

The hospital staff consisted of a medical director, two residents, four interns, two registered nurses, and assorted aides. Their spirit was tremendous, their desire to learn was great, and the care given the patients was tremendous in the face of meager supplies and equipment.

Every morning I made rounds on the entire hos-

pital, discussed diagnosis and treatment, and then had a short conference or lecture until 11:30 AM. In the afternoons, I worked in the outpatient department until about 5 PM. My inability to speak Spanish was a definite handicap, but Mrs. Grace Hoehman, the gracious wife of the Mennonite pastor, was our interpreter. I learned a tremendous amount of tropical medicine and acquired an appreciation of a really needy nation.

One of the happiest days of our visit was the arrival of drugs from the Medical Assistance Program. The budget for medicine in this hospital for one year is \$8,500. This lasts about three months and the remainder of the year the patients depend on gifts and samples for their survival. A little boy operated on for a perforated cecum had no preoperative glucose and only aspirin for pain. Many continue with their parasitic infestations because the supply of medicine is exhausted.

Our host, Mr. Miguel Kawas, was most gracious and did everything to make our stay comfortable. He is a prominent businessman who gives freely of his time and money to Atlantida Hospital. As president of the board, he pleads with everyone for the desperate needs of the poor of Honduras—drugs, vitamins, iron, antibiotics, sheets, beds, instruments, and protein supplements. They are also in desperate need of an operating table and operating light.

In summary, innumerable critically ill patients desperately need professional help. There is a special need for surgeons and specialists in ENT, orthopedics, and dermatology to serve for any period of time. Medical supplies and equipment are urgently needed. And, the ability to speak Spanish would certainly help future volunteers.

Charles H. Williams, MD  
Pasadena, Maryland

\* The April 1971 issue of Reader's Digest contains an article entitled "Doctors Who Take Vacations for Humanity" concerning physicians who volunteer to work overseas while on vacation.



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**MAY 12, 13, 14**  
**MEDICAL AND CHIRURGICAL**  
**FACULTY OF MARYLAND**  
**AT THE**  
**BALTIMORE CIVIC CENTER**

In addition to the many prominent physicians listed in previous issues of the Maryland State Medical Journal who will participate in the Annual Meeting Program will be **NICHOLAS J. PISACANO, MD,**  
**LAWRENCE K. PICKETT,**  
**MD, and J. ALEX HALLER, JR., MD.\***

The I. Ridgeway Trimble Fund Lecture will be presented on Thursday afternoon, May 13, by **Lawrence K. Pickett, MD**, Professor of Surgery and Pediatrics, Yale University School of Medicine; and



**Dr. Pickett**

Chief, Pediatric Surgical Division, Department of Surgery. In honor of Dr. Trimble, who was born in 1861, the decade in which the first pediatric surgical texts made their appearance, Dr. Pickett has chosen for his subject, **PEDIATRIC SURGERY: A CENTURY OF PROGRESS.** Dr. Pickett, who was born in Baltimore, received his MD degree at Yale University School of Medicine. He served internships and residencies at the Children's Hospital and the Peter Bent Brigham Hospital in Boston. Between 1950 and 1964, Dr. Pickett was Clinical Associate Professor in Surgery at the State Uni-

\* See the January, February, and March Journals for capsule biographies of Alan F. Guttmacher, MD, Edward C. Rosenow, MD, G. Rainey Williams, MD, George E. Schreiner, MD, Marvin Cornblath, MD, Saul Krugman, MD, and Neil L. Chayet, LLB.



versity of New York Upstate Medical Center in Syracuse, and Associate Surgeon (Pediatric Surgery) at the Syracuse Memorial Hospital. On leave from these two positions from 1951 to 1953, he was a captain in the U.S. Army Medical Corps.

From 1964 to 1966, Dr. Pickett was Chairman of the Surgical Section of the American Academy of Pediatrics, and is currently on the Advisory Council for Pediatric Surgery of the American College of Surgeons and Chairman of the Medical Advisory Committee of the New Haven Chapter of the National Foundation. He has consultant appointments at several hospitals and is a member of numerous pediatric, surgical, and pediatric surgical associations. He has been a diplomate of the American Board of Surgery since 1951. Dr. Pickett is the author or coauthor of over 25 publications.



**Dr. Haller**

On Thursday morning and afternoon, May 13, **J. Alex Haller, Jr., MD**, Robert Garrett Professor of Pediatric Surgery at The Johns Hopkins University School of Medicine, will present Grand Rounds on **CURRENT PROBLEMS IN PEDIATRICS: OPERATIVE MANAGEMENT**, in conjunction with Marvin Cornblath, MD, Profes-

sor and Head of the Department of Pediatrics at the University of Maryland School of Medicine. There will be three case presentations in the morning and three in the afternoon, without specific identification of surgical vs nonsurgical management.

Dr. Haller was born in Virginia. He received his BA at Vanderbilt University and his MD at The Johns Hopkins University School of Medicine. After an internship in the Department of Surgery at The Johns Hopkins Hospital, he went to the University of Zurich in Switzerland on a Rotary Foundation Fellowship in Pathology. Following this he was a Senior Assistant Surgeon in the United States Public Health Service at the National Heart Institute in Bethesda. Between 1955 and 1959, he was Assistant Resident Surgeon and Resident Surgeon at The Johns Hopkins Hospital.

From 1962 to 1963, Dr. Haller was visiting Assistant Professor of Surgery, University of Pennsylvania School of Medicine, Wistar Institute in Philadelphia, while studying organ transplantation and tissue immunology under Rupert E. Billingham, MD. He has had several appointments at the University of Louisville School of Medicine, such as Assistant Professor of Surgery and Chief of the Section of Pediatric Surgery. Currently, in addition to being Robert Garrett Professor of Pediatric Surgery, Dr. Haller is Children's Surgeon-in-Charge at The Johns Hopkins Hospital.

Dr. Haller's honors and awards include diplomate of the National Board of Medical Examiners, American Board of Surgery, and American Board of Thoracic Surgery; Markle Scholar in Medical Science; and Outstanding Clinical Professor at the University of Louisville School of Medicine. He is a member of numerous medical, surgical, and pediatric associations, honor societies, and fraternities. To date, Dr. Haller has 150 publications to his credit.

"**SWEET ARE THE USES . . .**" will be the subject of the George M. Boyer, MD, lecture to be given on Friday morning, May 14, by **Nicholas J. Pisacano, MD**. Dr. Pisacano is Assistant Dean of the College of Allied Health of the University of Kentucky Medical Center and Secretary of the American Board of Family Practice.

Dr. Pisacano was born in Philadelphia, received his undergraduate education at the Western Maryland College, and his MD degree from Hahnemann



**Dr. Pisacano**

Medical College. He served an internship and residency at the Stamford Hospital in Connecticut. For two years he was in rural practice in Vermont, followed by seven years in city practice in Philadelphia. While in the latter location, Dr. Pisacano was Medical Director of the Philadelphia Division of the American Cancer Society, and

President of the Philadelphia Academy of General Practice. Currently, in addition to the previously mentioned appointments at the University of Kentucky Medical Center, Dr. Pisacano is Chairman of Continuing Education, Associate Professor of Medicine, and Director of the Family Practice Training Program. He is also Associate Professor of Human Biology, and Assistant Dean in the College of Arts and Sciences.

Dr. Pisacano is faculty advisor to many student organizations and serves on numerous committees at the University of Kentucky Medical Center. He is Secretary of the Section of General Practice of the American Medical Association, in which organization he is also a member of several committees. As well as serving on committees in the Kentucky Medical Association, Dr. Pisacano is President of the Blue Grass Chapter of the Kentucky Academy of General Practice. Included in the many awards bestowed on Dr. Pisacano are *Most Popular Professor, University of Kentucky*; *Distinguished Teaching Award*; *Special Award by the Kentucky Academy of General Practice for Furthering the Teaching of Family Practice*; and *Special Recognition Plaque by SAMA for Service to Medical Students and Medical Education*.



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# ART AND HOBBY EXHIBIT

## Annual Meeting of the Medical and Chirurgical Faculty

### MAY 12, 13, 14, 1971      Baltimore Civic Center

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#### APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....
  2. Amount of space required—depth, width, and height: .....
  3. Electrical or other requirements: .....
  4. Name of exhibitor: .....  
Please print
  5. Address of exhibitor: .....
  6. Telephone number of exhibitor: .....
- 

An Art and Hobby Exhibit will be held during the 173rd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to the Baltimore Civic Center, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, May 11, 1971. They must be removed on Friday, May 14, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.

A Hobby Corner at the Semiannual Meeting of the Faculty in Hershey created a great deal of interest. LET'S MAKE IT A REAL "SHOW" FOR THE 1971 ANNUAL MEETING. SUBMIT YOUR ENTRIES NOW!





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A new contest which recognizes outstanding communications about wine and health has been announced. One thousand dollar prizes will be awarded in three categories for works on the health aspects of wine.

The works must have been published during the fiscal year July 1, 1970 to June 30, 1971 in public newspapers and magazines or medical publications, or given on radio and television broadcasts.

Deadline for submission of entries in July 31, 1971. Write: Administrator, Wine and Health Writing Awards, Suite 1307, 703 Market St., San Francisco, California 94103.

\* \* \*

**Joseph A. Lilli** has been named administrator of Mt. Wilson State Hospital, in Mt. Wilson, Maryland. The announcement was made by Dr. Edyth H. Schoenrich, Director of the Bureau of Chronic Diseases of the State Department of Health.

Mr. Lilli is the first nonmedical administrator of Mt. Wilson in the facility's 46-year history. Mt. Wilson is one of two state hospitals specializing in the treatment and cure of tuberculosis and other related respiratory diseases.

A native of Pennsylvania, Mr. Lilli has served in an administrative capacity at the Bon Secours Hospital in Baltimore.

\* \* \*

A call has been issued for papers to be presented at the 24th annual Conference on Engineering in Medicine and Biology, to be held October 31 through November 4, 1971 at the International Hotel in Las Vegas. Deadline for receipt of completed abstract forms is June 18, 1971.

Papers are invited in seven broad areas: delivery of health care; instrumentation; engineering and biological systems; engineering in predictive medicine;

## MEDICAL NEWS

information and library systems; law, ethics and society; and rehabilitation.

Author information kits are available from William T. Maloney, Conference Coordinator, 1971 ACEMB, 6 Beacon St., Suite 620, Boston, Massachusetts 02108.

\* \* \*

Sister Alberta, DC, president of the St. Agnes Hospital Board of Trustees, has announced that a two-phase renovation project is now underway on the hospital's seventh floor.

The seventh floor north wing will be converted into a modern, 27-bed Shock-Trauma and Surgical Intensive Care Unit. The second phase of the remodeling includes altering and adding 13 additional beds to the existing medical-surgical wing known as 7 South.

The trauma unit, when completed, will be under the direction of Everard F. Cox, MD, chairman of the Department of Surgery at St. Agnes.

With the completion of these changes and additions, the hospital will increase its bed capacity from 422 to 462 beds.

\* \* \*

**Harold E. Ramsey, MD**, Chief of Tumor Surgery of the U. S. Public Health Hospital in Baltimore, has been appointed professional education chairman of the American Cancer Society, Baltimore unit. The announcement was made by **Harry L. Berman, MD**, president.

As chairman of the committee, Dr. Ramsey will be respon-

sible for involving the medical community in the overall cancer-control program. He will also be involved in the professional education program which provides physicians, dentists, and nurses with films and literature, and sponsors seminars to teach the latest techniques of detection diagnosis and treatment of cancer.

A career surgeon in cancer research, Dr. Ramsey did postgraduate work with the U. S. Public Health Service.



**Dr. Ramsey**

\* \* \*

Nearly 20,000 physicians have been honored by the AMA for participation in continuing medical education programs.

The **Physician's Recognition Award**, established in 1969, has now been given to 19,338 physicians. The award is given for a minimum of 150 credit hours of continuing medical education earned over a continuous three-year qualifying period. At least



60 credit hours must come from any combination of required education categories.

The AMA award, other voluntary continuing education programs, and programs that would require of physicians evidence of continuance of professional privileges and for recertification and relicensure were reviewed at the Second National Conference of State Medical Association Representatives on Continuing Medical Education. The conference was sponsored by the AMA.

\* \* \*

The Health and Welfare Council has published a new and fully up-dated edition of the **Maryland Directory of Community Services**. This directory includes lists for more than 1,200 public and voluntary health, welfare, recreation, education, library, employment, courts and correctional, legal service, housing, and similar organizations.

The directory may be ordered from the Health and Welfare Council of the Baltimore Area, Inc., 200 East Lexington Street, Baltimore, Md. 21202. The

price for single copies to HWC member agencies is \$3; other agencies and individuals—\$3.50.

\* \* \*

A postage stamp has been designed to salute blood donors and to urge increased participation in this vital program. The announcement was recently made by Postmaster General Winton M. Blount.

The six-cent stamp was issued in New York city on March 12, in conjunction with the International Philatelic Exhibition.

The theme of the stamp is "Giving Blood Saves Lives".

Only about 3% of eligible American donors give blood, according to Mr. Blount, himself a donor. He feels that the postage stamp will focus attention on the problem of short supply. A French blood donors stamp is credited with trebling the amount of blood contributed there.

\* \* \*

**Colonel Dan Crozier**, commanding officer of the U. S. Army Medical Research Institute of Infectious Diseases at Fort Detrick, recently received

the 28th Annual Gorgas Medal.

The medal, with a citation and an honorarium, was presented by the Association of Military Surgeons of the United States at their annual meeting in Washington, D. C.

The award, established in 1942 by Wyeth Laboratories, honors Major General William C. Gorgas, who conducted his public health programs in the Panama Canal Zone. Dr. Gorgas' public health measures over 60 years ago controlled yellow fever and malaria in Panama and made possible the building of the Panama Canal. Each year, the Association of Military Surgeons selects the individual to be honored for contributions in the field of preventive medicine.

The citation honors Colonel Crozier for his "noteworthy scientific contributions to the understanding of infectious disease processes and the development and testing of vaccines," and for his leadership "in the development of this nation's present medical defensive posture against the threat of bacteriological warfare."

The 28th annual Gorgas Medal for accomplishments in preventive medicine is presented to Colonel Dan Crozier (right), U.S. Army Medical Corps, during the meeting of the Association of Military Surgeons in Washington, D.C. Making the presentation is George E. Farrar, Jr., MD, Director of Medical Services for Wyeth Laboratories, which sponsors the medal.







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Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
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Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

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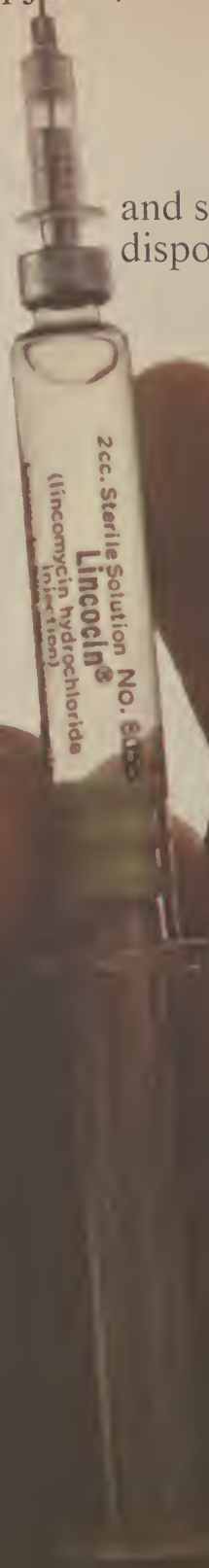
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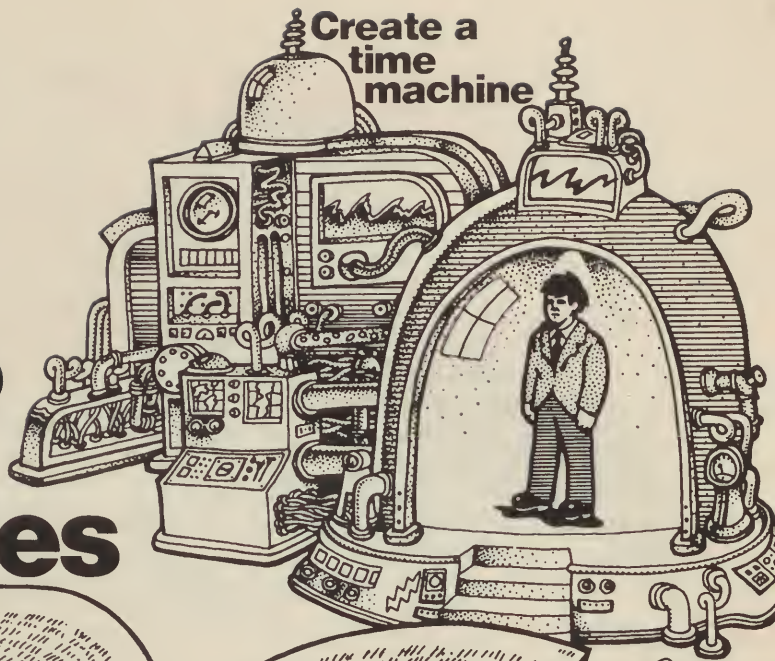
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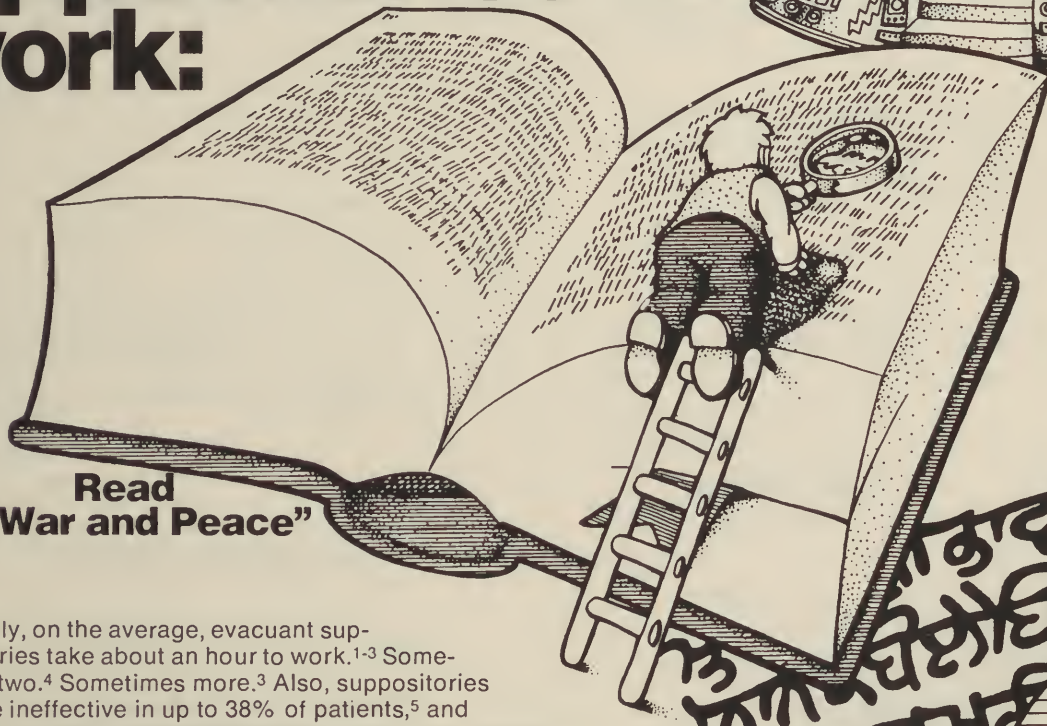
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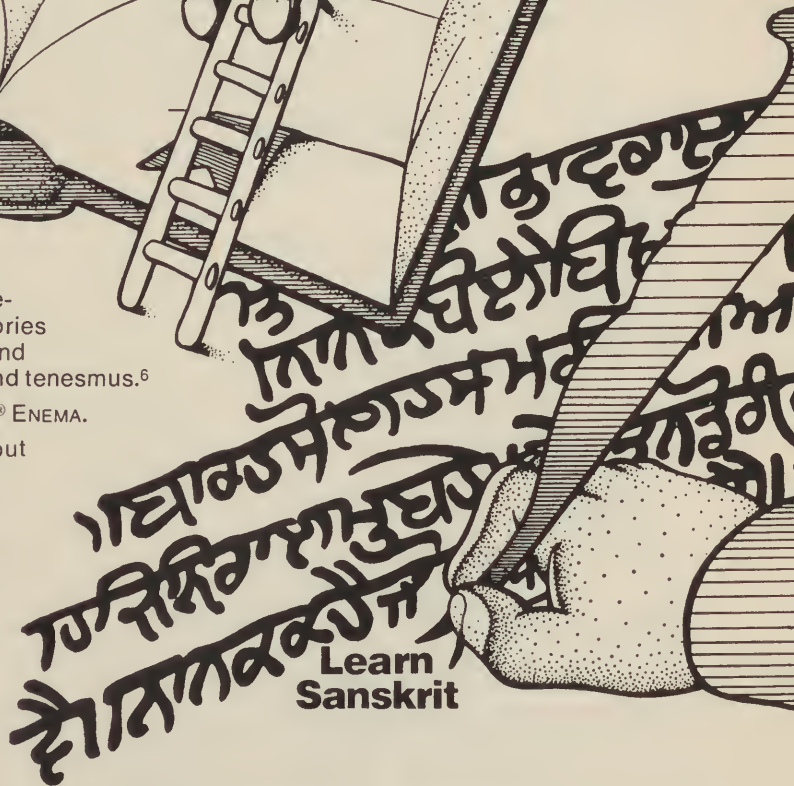
Actually, on the average, evacuant suppositories take about an hour to work.<sup>1-3</sup> Sometimes two.<sup>4</sup> Sometimes more.<sup>3</sup> Also, suppositories can be ineffective in up to 38% of patients,<sup>5</sup> and not infrequently produce smarting, burning and tenesmus.<sup>6</sup>

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Warning: Frequent or prolonged use of enemas may result in dependence. Take only when needed or when prescribed by a physician. Do not use when nausea, vomiting or abdominal pain is present. Caution: Do not administer to children under two years of age unless directed by a physician.

References: 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriatr Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.

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# MEDIC

## 1971 SCHEDULE

### OF POSTGRADUATE PROGRAMS

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**APRIL 23, 1971—12:30 PM**

#### **MIGRAINE AND RELATED HEADACHES**

**William G. Speed, III, MD**

Assistant Professor of Medicine

Johns Hopkins University School of Medicine

**SPONSOR: FREDERICK MEMORIAL HOSPITAL**

Replays: Monday, April 26, 1971	12:30 PM
Wednesday, April 28, 1971	7:30 AM
	9:00 AM
	2:00 PM

**APRIL 30, 1971—12:30 PM**

#### **UNEXPLAINED FEVER IN INFANTS**

**Fred J. Heldrich, Jr., MD**

Chairman, Department of Pediatrics

St. Agnes Hospital

Assistant Professor of Pediatrics

Johns Hopkins University School of Medicine

**SPONSOR: ST. AGNES HOSPITAL**

Replays: Monday, May 3, 1971	12:30 PM
Wednesday, May 5, 1971	7:30 AM
	9:00 AM
	2:00 PM

**MAY 5, 1971—8:00 PM**

#### **REPARATIVE CARDIAC SURGERY**

**Vincent L. Gott, MD**

Professor of Surgery

Johns Hopkins University School of Medicine

**J. O'Neal Humphries, MD**

Associate Professor of Medicine

Johns Hopkins University School of Medicine

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MEDICAL CENTER**

Replays: Friday, May 7, 1971	12:30 PM
Monday, May 10, 1971	12:30 PM
Wednesday, May 12, 1971	7:30 AM
	9:00 AM
	2:00 PM

**MAY 14, 1971—12:30 PM**

#### **OCCUPATIONAL DERMATOSIS**

**Harry M. Robinson, MD**

Professor and Head

Department of Dermatology

University of Maryland School of Medicine

**Sponsor: ST. AGNES HOSPITAL**

Replays: Monday, May 17, 1971	12:30 PM
Wednesday, May 19, 1971	7:30 AM
	9:00 AM
	2:00 PM

**MAY 21, 1971—12:30 PM**

#### **OBSTRUCTIVE PULMONARY DISEASE**

**Douglas G. Carroll, Jr., MD**

Associate Professor of Medicine

Johns Hopkins University School of Medicine

**Stephen M. Nagy, Jr., MD**

Fellow in Medicine

Johns Hopkins University School of Medicine

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Replays: Monday, May 24, 1971	12:30 PM
Wednesday, May 26, 1971	7:30 AM
	9:00 AM
	2:00 PM

**MAY 28, 1971—12:30 PM**

#### **ENCEPHALOPATHY—LEAD**

**Julian J. Chisolm, Jr., MD**

Associate Professor of Pediatrics

Johns Hopkins University School of Medicine

**Sponsor: FREDERICK MEMORIAL HOSPITAL**

Replays: Monday, May 31, 1971	12:30 PM
Wednesday, June 2, 1971	7:30 AM
	9:00 AM
	2:00 PM

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#### **CONTINUING PROGRAMS**

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(Heard at participating hospitals only)

#### **TUESDAY MORNINGS — 11:30 AM**

**MEDICAL GRAND ROUNDS**

University of Maryland Hospital

#### **WEDNESDAYS — 12 NOON**

**C. P. C.**

The Johns Hopkins Hospital

#### **SATURDAY MORNINGS — 8:00 AM**

**PEDIATRIC GRAND ROUNDS**

The Johns Hopkins Hospital

#### **SATURDAY MORNINGS — 10:00 AM**

**MEDICAL GRAND ROUNDS**

The Johns Hopkins Hospital



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## SPECIAL INTEREST PROGRAMS

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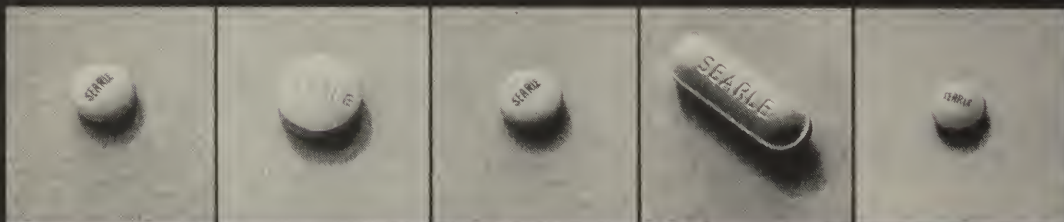
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**Indications:** Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

**Contraindications:** Glaucoma, severe cardiac disease.

**Precautions:** Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

**Side Effects:** The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

**Dosage:** The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

**Pro-Banthine® 15 mg.**

(propantheline bromide)

with

**Dartal® 5 mg.**

(thiopropazate dihydrochloride)

**Indications:** Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

**Contraindications:** Glaucoma, severe cardiac disease.

**Warnings:** Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

**Side Effects:** Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

**Adult Dosage:** One tablet three times a day.

**Pro-Banthine® 15 mg.**

(propantheline bromide)

with

**Phenobarbital 15 mg.**

**Warning:** May be habit-forming.

For **Indications**, **Contraindications**, **Precautions**, **Side Effects** and **Dosage** see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

**Pro-Banthine P.A.®**

prolonged acting brand of propantheline bromide

For **Indications**, **Contraindications**, **Precautions** and **Side Effects** see Pro-Banthine.

**Dosage Form:** Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

**Dosage:** The recommended initial dosage is one tablet in the morning and one at night.









**ARTHUR E. COCCO, MD**  
Journal Representative

## **Baltimore City Medical Society**

# **Board of Directors Meets**

A meeting of the Board of Directors was called to order by the president, Philip F. Wagley, MD, at 4:30 PM, on February 9, 1971. The minutes of the previous meeting were approved as distributed.

Emeritus membership was recommended for Sigmund R. Nowak, MD, who retired from practice on January 1, 1971.

Dues for 1971 were waived for Emmanuel A. Schimunek, MD, and Andre E. Calas, MD, both of whom have been ill and are unable to practice at the present time.

An apparently fraudulent application for membership was considered and referred to the Membership Committee for further investigation and report.

Letters had been received from several members of Congress in response to the telegram sent to President Nixon and the Secretary of HEW questioning the legality of closing the USPHS Hospital. No response had been received from either the President or Secretary Richardson. It was reported that it was the general consensus in Washington at this time that the hospitals will not be closed; however, no definite information is available.

Since there was no quorum at the February 5 meeting of the society due to its postponement because of inclement weather, the board felt that the president should exercise his authority under the bylaws so that the applicants for membership who did appear at the February meeting need not attend another meeting. Their names will be read at the March meeting so that they can be elected. Dr. Wagley commented that this was the first group of applicants to attend the newly instituted orientation meetings and all were most interested in the functions of the society. He felt strongly that these meetings should be continued and would help generate enthusiasm among the new members.

There was some discussion about the continuing poor attendance at meetings. A suggestion was made that possibly the bylaws should be amended to require attendance at one meeting a year in order to retain membership in the society. The suggestion was that if a physician did not attend one meeting during the year, he would receive a notice. The second year he did not attend he would be dropped from membership. Since the society offers the gateway to group insurance, board certification in some groups and, in some instances, hospital privileges, it was felt that this type of bylaw would certainly be enforceable.

However, there was much discussion on this and it was the general feeling of the board that coercion should not be used to bolster meeting attendance. Rather, it would be necessary to create interest among the members in the activities of the society. This will be a continuing item on the agenda and it is hoped that further suggestions will be forthcoming.

John B. De Hoff, MD, had written a letter (a portion of which is quoted below) to the president concerning the lack of contributory activity on the part of the society in the community. Dr. De Hoff feels that the society has an important role to play in the community and must work to assume leadership in the field of the delivery of health care through various programs now being planned or through innovative programs. It was noted that Dr. De Hoff had recently accepted the appointment as chairman of the Policy and Planning Committee for the society and the board felt that this certainly was a matter that should be discussed in that committee and appropriate recommendations made.

Portion of letter from John B. De Hoff, MD, to Philip F. Wagley, MD:



"In these times of rapidly changing forms of medical practice, and with serious consideration now being given by the Medical and Chirurgical Faculty to their moving from the center of Baltimore to a location in a surrounding suburban area, it may be well for the Society to begin now to debate future courses of action it might take. Some possible steps have already been proposed: Maintain the present location and join with other professional society groups to help meet expenses. Maintain a small office, and meet regularly at different Baltimore hospitals. Disband. Merge with one or more county medical societies. Locate in or work out of one or both of the medical schools. Seek support from the Baltimore City Health Department in matters such as office space and clerical help.

May I suggest that the Society has a more positive alternative which deserves serious and intent, perhaps even vigorous investigation. This is the development of a Society sponsored group health complex. Such a proposal is neither new nor untried, but events of the last five years and the activities of influential congressmen seem to

be developing a framework into which the Society can fit appropriately and with opportunities to express its ethical, professional and scientific concerns. Certain additional benefits or economies could result in the event that the Society should develop a center for ambulatory care, for example: A central library would be available to members; peer review or other quality control consultatory services could be developed; the Society would have increased concern and authority in areas of health care; improved liaison with members and lay groups could ensue.

There are many reasons why the Board of Directors should debate the Society's future, and with advice and consultation from experts in many other fields. The rapidly changing medical world makes such debate of some urgency."

The Board approved the attendance of Mrs. Silk at a two-day conference on legislation to be held in Washington, D.C. sponsored by AMA-AMPAC on March 13 and 14, 1971.

There being no further business, the meeting was adjourned at 6 PM.

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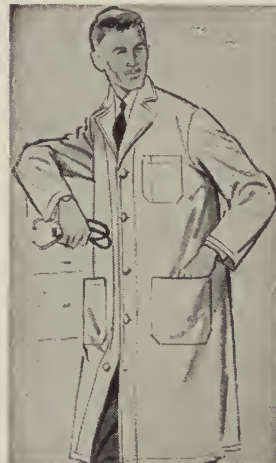
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THE PHARMACOLOGICAL BASIS OF THERAPEUTICS  
3rd Edition, page 522



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Capsule in bottles

of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

#### PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

**DOSAGE:** One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

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**NOTE:** The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.



ARTHUR E. COCCO, MD, FACP  
Chairman, Peer Review Committee  
Medical and Chirurgical Faculty  
of the State of Maryland

# Peer Review in the State of Maryland

The American Medical Association has finally begun officially promoting "peer review". It is regrettable that this was not done years ago, and it is hoped that this effort will result in meaningful and productive performance at the local level by peer review groups through strong and effective promotion and support of such efforts by state and county medical societies. For years, society has increasingly viewed escalating health costs with alarm. Too often, individual physicians, hospital staff, and organized medicine have side-stepped responsibility by pointing out that the largest, single component of the health dollar expenditure is for hospital care, not for physician services. Individually, we have wrung our hands and berated rising hospital costs, unnecessary admissions, and prescribing or "shooting the works" in ordering X-ray or laboratory services. It is always the other guy, never ourselves, who is guilty of such practices. We have overlooked the fact that it is the individual physician who admits and discharges the patient, and who orders the services the patient receives. The services we order and the competitive gadgetry we demand at our hospitals are major factors in cost escalation.

## Definition

In defining peer review, peer means equal and, as we know, some are more equal than others! The simplest definition of a "peer" in this context is an individual who has an MD degree. Quite obviously, many more qualities are desirable. For instance, the

reviewer should have obtained about the same education as the one whom he reviews. Thus, specialty review is preferable. The reviewer should not be in an administrative position or retired, but must be in active practice. He will thus know the standards and practices of his community, as well as its inherent medical progress. In addition, he should have an outstanding reputation so that his colleagues will accept his judgment—mediocre physicians simply will not do for review committees. The reluctance of physicians to ride herd and pass judgment on their colleagues is understandable, but such review is essential to effective quality and cost control.

As a profession, medicine still has a long way to go before it achieves the utilization review performance the public has a right to expect. We, as physicians, also have a long way to go until we can live up to our own self-proclaimed responsibility. True, as a result of third-party insurance carrier efforts and now Medicare and Medicaid requirements, most hospital staffs have utilization review committees. Too often these are pro forma bodies which go through the motions of meeting and rubber stamping the status quo.

However, increasing numbers of utilization review committees do function effectively, take their responsibilities seriously, and produce results, thus proving it can be done. All important is the existence of a review committee which will examine the evidence and render a valid medical opinion in the light of community practice and customs. (We are not referring to long-established hospital committees such



as the ones for hospital records and tissues.) In addition, the physician must be provided with a chance to appear before the committee to explain his side of the case. Furthermore, there must be provisions made for recourse to an appeals mechanism at a higher level. Top-notch men with specialty representation must be available either in an active or in a consulting capacity. Third party (insurance carriers) should attend the meetings to advise on the problems of the case.

In the long run, all this means not only cost, but also quality control, which in turn depends on utilization control with all its advantages (including educational ones) for management, physicians and, at times, even the patients. The range of responsibility of peer review will reach further and further as the medical profession progresses, helped by computer technology, and learns more and more about the different aspects of care. The starting point, especially in government programs, has been cost control, but in many places other aspects enter immediately into it. Even cost review alone is composed of many factors: the cost of a single fee which may be an overcharge (but in some cases may be justified for the complicated service rendered); the cost of a laboratory panel obtained at automated low cost but charged as individual fees to the patient; and overuse of medical services (too many visits for the given diagnosis, too many injections, too many drugs).

What causes such practices? It may be lack of knowledge due to "not keeping up", or possibly greed. It may also be pressure by the patient who, for instance, was raised in a particular environment and, demanding more services, creates overutilization. In any case, it is easy to see that a fee of \$5 six times a month is very expensive in comparison with a fee of \$10 for one visit a month. On the other hand, underutilization by an overly busy physician or one lacking in knowledge, might even be worse and may actually imply the lack of necessary care. It has been shown again and again that the percentage of such obvious violations is extremely small but, even if it is small, we as physicians should control that small percentage. And let us not forget that a small percentage of physicians might conceivably be seeing a disproportionately large number of patients.

### **Problems of Peer Review**

What are the problems of peer review? Foremost is the natural reluctance to accept it. Nobody likes to have a "big brother" looking over his shoulder. Review of claims, such as we have seen, of necessity brings the quality of care into focus—a very touchy subject—and yet I am not aware of any other profession having instituted such voluntary review. Even after peer review becomes widely accepted, the phy-

sician will still have great difficulty in the small community: the physician who was reviewed last night may meet his reviewers in the hall the next morning, and may even be the one who refers cases to him, or vice versa. Under such circumstances, peer review within the community becomes practically impossible, and it usually has to be taken over by a larger impersonal committee.

What is the power of such a mechanism? Certainly it is extremely great, since only the most intransigent defiant will not be impressed when confronted by a committee of his peers. Interestingly enough, a varying influential factor, usually not even mentioned when peer review is discussed, is the deterrent influence of such review; namely, to prevent unacceptable human or medical behavior.

Educational influence should be the leading function of peer review. This can be and has been done in many successful ways which have protected all three parties. It is generally agreed that these committees should not have the power of disciplinary action, but that such decision should be handed on to the jurisdiction of others, which may vary according to the set-up in the particular area. In this state, the Disciplinary Commission and the Medical Mediation Committee of the Medical and Chirurgical Faculty has served in this capacity.

Lest there be any misunderstanding, let me emphatically repeat that the purpose of peer review is not to criticize, but only to examine the evidence and render valid medical opinion. The outcome may be defense instead of criticism. For instance, a committee may be asked to review the bill of an internist. The diagnosis on the claim for daily hospital visits reads "postgastrectomy". The insurance coverage was for one physician only, "unless the medical skill of two physicians is needed". The surgeon was an outstanding man who, no doubt, could take postoperative care of his patient. The internist also was an outstanding man, who would hardly have attended the patient unless needed. The hospital bill was requested. It showed daily fasting blood sugars and intermittent positive pressure breathing four times daily. The explanation lies in the medical evidence—diabetes and pulmonary complications. Result of the review: the internist was given advice on how to fill out his claim!

Thus, when exercised correctly, the power of the peer review mechanism is tremendous, and it is most impressive to see it in action. I repeat—it behooves all of us to institute peer review as soon as possible to protect quality, to hold down costs, and to help us work closely together.

### **Peer Review Committee of the Medical and Chirurgical Faculty**

The Medical and Chirurgical Faculty of the State of Maryland has had a functioning Peer Review



Committee for the past year. The committee is authorized and defined in the Bylaws of the State Society and was adopted by the Faculty in April 1970.

# NEW

(CAPS ADDED)

THE PRESIDENT SHALL APPOINT A PEER REVIEW COMMITTEE OF NINE MEMBERS, THREE OF WHOM SHALL BE APPOINTED ANNUALLY FOR THREE-YEAR TERMS. IT SHALL BE THE DUTY OF THIS COMMITTEE TO ADVISE THIRD PARTY AND OTHER AGENCIES AS TO THE APPROPRIATENESS OF MEDICAL CARE RENDERED BY MARYLAND PHYSICIANS IN INSTITUTIONS AND OFFICES

OR OTHER LOCATIONS WHERE HEALTH CARE IS RENDERED. IT SHALL DEVELOP SUITABLE CRITERIA TO ADEQUATELY EVALUATE THE INDIVIDUAL AND COLLECTIVE VOLUME, COST AND QUALITY OF MEDICAL CARE WHEREVER PROVIDED. THE COMMITTEE SHALL STIMULATE AREA HOSPITALS' MEDICAL STAFFS TO DEVELOP APPROPRIATE MECHANISMS SUCH AS UTILIZATION COMMITTEES FOR REVIEW OF HOSPITAL ADMISSIONS WITH RESPECT TO NEED FOR ADMISSION, LENGTHS OF STAY, DISCHARGE PRACTICES AND EVALUATION OF SERVICES ORDERED AND PROVIDED. THE CHAIRMAN SHALL BE DESIGNATED ANNUALLY BY THE PRESIDENT.

The present membership of this Committee includes:

Name and Address	Component	Specialty
Arthur E. Cocco, MD, Chairman 107 E. Chase St. Baltimore, Maryland 21202	Baltimore City	Gastroenterology
Harry F. Klinefelter, MD 550 N. Broadway Baltimore, Maryland 21205	Baltimore City	Internal Medicine
Katherine H. Borkovich, MD 550 N. Broadway Baltimore, Maryland 21205	Baltimore City	Internal Medicine
Charles H. Ligon, MD Sandy Spring, Maryland 20860	Montgomery County	General Practice General Surgery
Earl C. Clay, Jr., MD 10478 Gray Owl Garth Columbia, Maryland 21043	Baltimore City	General Surgery
John R. Davis, MD Medical Arts Bldg. Baltimore, Maryland 21201	Baltimore City	Internal Medicine
Watson P. Kime, MD 1010 St. Paul St. Baltimore, Maryland 21202	Baltimore City	Pathology
Richard C. Arbogast, MD 121 Cathedral St. Annapolis, Maryland 21401	Anne Arundel County	Psychiatry
Leeds E. Katzen, MD Mercy Hospital Baltimore, Maryland 21201	Baltimore City	Ophthalmology
Robert M. Heyssel Director, Outpatient Dept. Johns Hopkins Hospital Baltimore, Maryland 21205	Baltimore City	Medicine
John G. Wiswell University of Maryland Hospital Baltimore, Maryland 21201	Baltimore City	Endocrinology



This committee has met regularly and the minutes of their meetings are on file in the office of the State Medical Society. The members of the committee have met with representatives from Maryland Health Services, trade unions, researchers in the field of health-care delivery, various state audit foundations, and the National Council of Health Insurance. This committee has done an outstanding job during the past year with each member performing in an exemplary manner. The general problems confronting this group have been those of organization, case review, establishment of local peer-review groups and long-range plans for "State Regional Medical Audit". I am happy to report to the membership that strides have been made in all four areas. A formal draft of our peer review program was recently presented to and accepted by the Council of the Med-Chi.

### Proposed Peer Review Program

It is necessary to define the difference between peer review and utilization review. **Utilization Review** is a question of **utilization of facilities** (such as hospital beds, extended-care beds, diagnostic facilities, etc.); **Peer Review** is an analysis of the **quality, need for services rendered, and applicability of the medical care provided** to a patient. It is not intended to save third-party money but is only intended to make sure that **good quality medicine is practiced**.

To reemphasize, quality control is the prime objective of peer review and cannot be allowed to become secondary to cost control. Peer review must be applied equally to the public at large as well as to patients who are recipients of benefits through public assistance or third-party payment systems.

**Proposed Definition:** To promote effective, efficient, and economical delivery of health services for which payment may be made through application of professional standards review procedures which would assure that such services are of appropriate quality, and are provided only when necessary and are consistent with professional, recognized health-care standards.

**Organization:** Professional or peer review groups would be organized on a component society level; or where local society membership is sufficiently small to warrant, a regional group would be established. It is conceivable that groups may not be used within their own county or region, but may be assigned to areas outside the area in which they practice to review activities with which they have no direct or indirect involvement.

In the initial stages, the attention of these groups will be directed toward:

1. Determining whether the services are necessary to proper health care;

2. Meeting recognized professional standards of health care within the community;
3. Providing care in the most economical fashion consistent with recognized standards of care;
4. Giving those physicians involved the opportunity to present their viewpoints.

### Suggested Peer Review Program for Implementation on a Local Level

In order for physicians to accept a peer review system affecting their office practice, it is necessary that they have a strong hand in its development and operation. The material contained in the following recommended guidelines, therefore, is meant to be used only as a guideline and is not, necessarily, to be adopted as presented. It is recognized that situations vary from community to community and, indeed, within communities themselves. Variations, therefore, can be made in these proposed guidelines and they need not be adopted in toto.

A program of peer review for physicians' office services is dependent on the data obtained from **any** source. At the present time, coordinated information is only available from third-party payors who accumulate this data. Often the method of accumulation does not readily lend itself to retrieval in an acceptable form for peer review activity.

While it is relatively easy to analyze and take action on cases where abuses are self-evident (the third-party payor having already gathered data sufficient to warrant having the case sent to the local peer review committee for its consideration), it is not so easy to obtain data on a physician's practice when the patient himself is paying the bill. In those cases, where the patient expresses concern in writing to the local medical society, peer review automatically goes into operation. In some areas, this review constitutes only a determination as to whether or not the fee charged is reasonable.

In some of these latter instances, the component society evaluating the reasonableness of the fee could extend its review to the quality of the care provided by the physician. The Faculty's Mediation Committee and Medical Economics Committee have, on occasion, done just this, particularly when the case would appear to be questionable from the standpoint of quality, quantity or other facets of the care that should be looked into. To institute review on this basis, however, reflects a "hit or miss" attitude. The physician who has a good patient-physician relationship may never have a patient complaint filed against him. The patient may be perfectly happy in paying for services that are unnecessary or that he (the patient) feels are important to him. Conversely, the physician who exercises good judgment, but in exercising this judgment fails to develop a good rapport with his patient, might subject himself to com-



plaints which are unjustified by the facts in the case.

In summary, therefore, local programs should aim at review of cases brought to their attention by either third-party carriers or by the state or local government, in Medicaid cases. Attention should also be directed to those cases that arise as a result of a complaint registered with the local component society, if the situation warrants such peer review.

If local committees wish to have criteria to use in assessing the quality of medical care in individual medical practice, this data can be provided. (The California Medical Association has developed such data and copies can be made available. The committee strongly recommends, however, that these be developed locally because of possible variations that exist from community to community and from practices as they exist in California.)

### Third-Party Payors Role

At the present time, third-party payors do not have any practical system of submitting claims to the Faculty's Peer Review Committee or to local peer review committees when they come into existence.

In an effort to assist carriers in providing appropriate committees with a flow of data for review, it is suggested that:

1. Carriers set up a system of analysis of the percentage of claims paid to any one physician for certain procedures, as compared to the total number of claims paid for that procedure. Where there appears to be a disproportionate percentage of claims being paid to a physician this could be evaluated.
2. Carriers set up a system to spot-check claims submitted by physicians on the following or any other basis:
  - (a) All claims on a specific day from a specific physician.
  - (b) All claims in a specific time period for a specific diagnosis.
  - (c) All claims for a specific group of subscribers (group programs) to ascertain what specific percentage of employees or subscribers are receiving a large proportion of the claim dollar. When a disproportionate part of the group is receiving a disproportionate part of the claim dollar, an analysis can be made of the physicians rendering the care, to ascertain if review is necessary.
  - (d) An analysis of claims should be made to ascertain and select those physicians who "self-refer" for diagnostic tests (X-ray, EKG, laboratory, etc.) Also, the physician who does a disproportionate amount of dispensing of medication for which he charges.

3. Carriers should determine in four or five disease entities norms that can be followed. For instance, throat cultures should be taken in certain cases of upper respiratory infection. If a physician takes a culture in every case, his practices should be examined. If he takes no cultures, then his practice should be examined. The same thing could apply to antibiotics and chest X-rays.

4. Carriers should also develop data that would reveal any patient overutilization. For instance, any patient who uses the services of more than four providers would automatically be reviewed. In some cases, this would entail scrutiny of Blue Cross records which is the agent that administers the prescription drug program.

5. The third party involved should also examine the total average cost per patient per year for services. Any physician should be examined if all his patients under the program have an apparent excessive cost per patient per year.

The above suggestions are basics which can be expanded as the program is developed and made available on a local level.

Many, of course, cannot be implemented until such time as the third-party agents provide data as outlined. The Peer Review Committee plans to meet with representatives of such groups to discuss this further and ascertain the length of time necessary before such information can be available. The Peer Review Committee supports the concept of present hospital utilization review systems in use in hospitals such as utilization review committees, tissue committees, PAS, and MAP.

### Compensatory Remuneration

It is anticipated that remuneration for services rendered by those serving on peer review committees will be negotiated.

A compilation of those cases reviewed by the peer review committee is being prepared and will be available to component societies.

In summary then, the state of Maryland is making strides to assure that the review of the delivery, equality, and cost of medical care is left to physicians, who in the long run are the most qualified to render such opinions. In this regard, we are ahead of many states and behind some; admittedly, more must be done. It is no longer a question of whether we want peer review or not, but rather how to make it work most effectively. The tired phrase, "if we don't do it others will", has never been more final than it is at this hour. It therefore behooves practicing physicians in our state to support "peer review" on the local level in order to assure their voice of opinion.



# **symposium on**

# **VIRAL DISEASES**

**This symposium, sponsored by the Medical and Chirurgical Faculty of Maryland and the National Communicable Disease Center, in cooperation with the Maryland State Department of Health, was held in the Faculty building in November 1969.**

**J**ohn Whitridge, Jr., MD, Chairman of the Committee on Postgraduate Education, Preventive Medicine, and Public Health of the Medical and Chirurgical Faculty, welcomed those present and made the introductory remarks.

*Richard B. Hornick, MD, Associate Professor of Medicine and Director of the Division of Infectious Diseases at the University of Maryland School of Medicine, opened the symposium with the following remarks:*

In the field of infectious diseases, most of the really exciting advances are occurring in virology. During this symposium, many of these advances will be discussed by our distinguished speakers. It seems that no matter what disease process is mentioned, there is evidence (good and bad) implicating viruses as the etiological agent. This includes diseases like diabetes mellitus, disseminated lupus and, of course, cancers.

Our discussion will encompass such topics as advances in viral vaccines and new concepts on the etiology of suspected viral diseases such as infectious mononucleosis and hepatitis. We can also look forward to hearing about means of stimulating nonspecific host mechanisms to fight viral infections.



An article reviewing hepatitis written a few years ago could have started by saying, "Nothing new on the Western Front". In a way, this continues to be true today, because hepatitis is one of the most frustrating diseases for virologists to study. For this reason, and because many of the more recent developments can be traced back a long way, I will start with a few historical comments.

# Hepatitis

**FRIEDRICH W. DEINHARDT, MD**  
Chairman  
Department of Microbiology  
Rush-Presbyterian-St. Luke's Medical Center  
Chicago, Illinois

The infectiousness of hepatitis or jaundice was first mentioned in the eighth century in a letter from Pope Zacharias to St. Boniface, then Archbishop of

Mainz in Germany. In his letter, Pope Zacharias said that people with jaundice should be separated lest others catch the contagion. Even so it took a



thousand years until McDonald, at the beginning of this century, predicted that infectious jaundice, or viral hepatitis as we call it today, probably was caused by an agent smaller than a bacteria and postulated that it was a virus.

McDonald's predictions were not confirmed until human volunteer experiments, during and after the last world war, established that the disease could be transmitted from a diseased individual to another normal human volunteer. These studies also established that there are two forms of viral hepatitis: one caused by Virus A, and the other by Virus B.

More often today we use the terms infectious hepatitis or short-incubation-period hepatitis, and serum hepatitis or long-incubation-period hepatitis. And the dictum is written in every textbook that the agent of infectious hepatitis or short-incubation-period disease can be transmitted, and usually *is* transmitted, via the anal-oral route, whereas serum hepatitis is transmitted *only* by injection (parenteral route) of serum, blood, or blood products. However, in 1938 Probert reported that a number of children in a children's institution developed serum hepatitis 60 days after human measles hyperimmune serum was given. Again, 60 days later, other children who had not received serum came down with the same disease. But, as this finding was contrary to the thinking of the time, and despite the fact that two other groups of investigators reported similar results in human volunteer experiments with hepatitis following yellow-fever vaccination (yellow-fever vaccine at that time contained human serum as a protective agent), these results were disregarded. Only during the last year has Dr. Krugman in his studies in Willowbrook (a large institution for mentally retarded children in New York) clearly shown that both types of hepatitis (short-incubation-period hepatitis and long-incubation-period hepatitis) can be transmitted by the anal-oral route.

### Different Types of Hepatitis

The short-incubation-period hepatitis, or MS-1 as it is termed in the Willowbrook studies, is usually milder (the MS-1 strain of virus causes a particularly mild disease which lasts only for a few days or, at the most, one to one and one half weeks) and is negative for Australia antigen. Gamma-globulin given in the incubation period prevents clinical disease but does not prevent infection and biochemical disease.

On the other hand, MS-2 or serum hepatitis has a longer incubation period of 60 to more than 100 days and is often a more severe disease lasting for weeks. It is usually positive for the Australia antigen, and cannot be prevented by treatment with human gamma-globulin.

Experiments with human volunteers after World

War II and experiments by Dr. Krugman in Willowbrook have clearly shown that an individual inoculated with infectious hepatitis materials is resistant to a second infection with the same material. I emphasize *the same materials* because we do not know at this time if there is more than one antigenic strain of infectious hepatitis. If the same individual had been challenged with serum hepatitis (long-incubation-period material), there would have been no protection. Similarly, if MS-2 type material is inoculated twice, the individual is usually protected against the second inoculation but protection is not 100%. So there is homologous protection, IH vs IH, and SH vs SH, but there is no heterologous or cross protection between infectious hepatitis and serum hepatitis.

The situation with serum hepatitis is, however, still somewhat unclear. Dr. Krugman has reported that a number of children over a period of years came down two or even three times with a disease typical of serum hepatitis. Whether this is reactivation of a chronic disease or a second infection from the outside will only be known by future experiments.

All the current definitions of the different types of hepatitis are somewhat misleading—they can be transmitted anal-orally or by injection of blood and blood products, and even the incubation periods overlap. So perhaps we would be wise to return to the earlier names of Virus A and Virus B hepatitis.

### Protection With Human Gamma-Globulin

Does human gamma-globulin protect against serum hepatitis or not?

In still unpublished experiments, Dr. Krugman has taken either MS-1 material or MS-2 material and has mixed it 50-50 with standard gamma-globulin. He incubated the two mixtures overnight at 4 C and administered them to groups of six to eight children, each group with appropriate controls. In the individuals who got MS-1 which had been exposed to human gamma-globulin, there was neither disease, nor biochemical or histological evidence of disease. In other words, there was full neutralization of the MS-1 material. In the same experiment with MS-2 or serum hepatitis, there was no difference between the controls and the individuals who got the mixture; equal numbers came down with the disease. The incubation period and the severity of the disease were identical, which I think shows very clearly that even under the conditions of a 50-50 neutralization test, human gamma-globulin had no influence on classical serum hepatitis.

This is further illustrated by a report from Creutzfeldt showing that if a Swiss human gamma-globulin preparation, which can be given intravenously, was mixed with blood for transfusion, there was a reduction in the total number of patients who came down with post-transfusion hepatitis. On reexamination



of his data, Dr. Creutzfeldt found that he actually had a two-peak curve of incidence of hepatitis after transfusion, one with a relatively short incubation period and one with a longer incubation period. And the only disease which he prevented with gamma-globulin was the short-incubation-period hepatitis. What he really eliminated was IH which, of course, can also be transmitted by a blood transfusion if the blood is donated at just the right time.

In other words, gamma-globulin will protect individuals against infectious hepatitis but not against what we used to call serum hepatitis.

### Attempts to Isolate Agents of Hepatitis

Three approaches have been used in efforts to isolate human hepatitis agents: (1) identification of agents in cell, tissue, or organ cultures, (2) transmission of disease to experimental animals, and (3) identification of agents by immunological methods.

Thus far, innumerable agents have been isolated and classified as candidate strains. They belong to almost all known virus groups and none have been shown to cause hepatitis.

### Transmission of Disease to Experimental Animals

A wide range of animals—from canaries to oysters to pigs to mice and primates—has been used in attempts to transmit human hepatitis to animals. The only animal species which occasionally gave positive results (that developed a hepatitis-like disease after the inoculation of human materials) were non-human primates. Hillis first reported that handlers of chimpanzees in the United States Air Force occasionally came down with hepatitis.

Since then, almost 20 small epidemics of hepatitis, each one associated with recently imported chimpanzees, usually young chimpanzees brought to zoos, have been reported. Had man become the experimental animal for chimpanzee hepatitis? Or had the cycle begun with man infecting the chimpanzee after capture and a subsequent retransmission back to man? These questions cannot be answered but the results stimulated a number of groups to examine nonhuman primates as experimental animals for hepatitis.

Dr. Holmes (from our laboratory) and I were working at that time with small South American primates, marmosets, for completely different purposes. We tried to infect these little animals with human materials and, to our great surprise, they developed typical hepatitis.

Our experimental plan was to inoculate IV 0.4 or 0.5 ml of a 1:2 dilution of acute plasma or serum from human cases of hepatitis into groups of five to eight marmosets. We then followed the blood chemistry of the animals weekly, or more frequently if abnormal values were observed, and did needle liver

biopsies both before inoculation and during the course of the experiment. These liver biopsies were coded and independently evaluated. About 50% of the inoculated human sera or plasmas induced hepatitis in marmosets, the disease was transmissible from marmoset to marmoset with great ease, and about 90% to 100% of the animals inoculated in the passage series developed biochemical and histological hepatitis. These experiments have been repeated by a total of eight laboratories, all of whom had no difficulty in easily producing this disease.

What are the characteristics of the agent causing the hepatitis in marmosets as we know them today? The density of the agent is 1.21 in cesium chloride density gradient centrifugation experiments done both by us and by Dr. Cline at Oak Ridge. The size should be 320 Å or smaller according to filtration experiments performed by Dr. Melnick's group. Sensitivity to ether (one criterion used for characterizing viruses) is still uncertain with some discrepancies between results of different laboratories, but there certainly is a partial ether resistance. Sensitivity to heat is similar to the heat sensitivity known from human volunteer experiments.

However, one question arose: Is this the transmission of an agent of human infectious hepatitis to marmosets or is it the activation of an agent the marmoset carries? This is a danger inherent in any attempts to transmit diseases to animals, eg, inoculation of saline into mice intracerebrally can cause choriomeningitis by activation of viruses carried by the mice. Of the eight laboratories working with this animal model system, only Dr. Melnick's group reported that they observed spontaneous hepatitis in control marmosets. This cast doubt on the validity of the results obtained by all other laboratories as none of the results could exclude the possibility that the observed disease was not the activation of a marmoset agent. Regardless of how many controls one includes, it is statistically very difficult to prove or disprove the possibility of a latent agent if inocula of unknown potency are used. For that reason we obtained coded preinoculation sera and acute phase sera of human volunteers that had been inoculated with MS-1 infectious hepatitis material. Experiments were done under a code which was broken only at the 90th day of the experiment. The preinoculation sera from three human volunteers who were later inoculated with MS-1 virus and developed disease did not produce disease in 18 inoculated marmosets; sera from the same volunteers taken on the first day of abnormal serum enzymes each induced hepatitis in five of six marmosets. Statistically, it is very difficult to explain the results in any other way but that the disease which we observe in marmosets is caused by the inoculum and not by the activation of a latent agent.

The disease observed in marmosets and the origi-



nal inocula were Australia antigen negative. Two sera which were Australia antigen positive have not produced disease in marmosets. So, it appears that marmosets may be susceptible to IH but not to SH. This would not be too surprising because SH is probably a quite different disease and the pathogenetic mechanisms are probably different.

#### Identification of Hepatitis Agents by Immunological Methods

An antigen has recently been identified in the serum of hepatitis patients; it also occurs in a number of patients with leukemia, Down's syndrome, and some other diseases, and it occurs rather frequently in primitive populations. The so-called Australia antigen is usually demonstrated by two methods, either an agar gel double diffusion method or, more recently, by complement fixation. Early studies of the distribution of Australia antigen were difficult to interpret. It was difficult to tell whether the antigen was associated with serum or with infectious hepatitis, or with both.

However, more recent studies showed that children in Willowbrook with MS-1 disease were always negative for Australia antigen, whereas the children with MS-2 disease of serum hepatitis were always positive for Australia antigen if the sera were examined at the right time. When the MS-1 disease from the Willowbrook children was transmitted to adult human volunteers and the adults were bled every three days during the incubation period and during the acute phase of the disease, none had Australia antigen in their serum. Under these experimental conditions it is clear that Australia antigen plays no role in MS-1 disease.

About eight studies of epidemics have now been reported; all were proven, single common source outbreaks in isolated populations and many hundred sera have been tested from these epidemics. All, with a very occasional exception, were negative for Australia antigen. In each instance, the exceptions could be explained by recent injection or some similar exposure. I think, therefore, that it is quite clear at this time that Australia antigen or hepatitis-associated-antigen is related only to serum hepatitis or the long-incubation-period hepatitis and not to infectious hepatitis.

Is Australia antigen the virus of serum hepatitis? Evidence that it is the virus of serum hepatitis is "propagation" which occurs in man, ie, individuals receiving blood containing Australia antigen come down more frequently with serum hepatitis and antigen can again be found in their serum. The antigen is particulate and is about 18  $m\mu$  to 20  $m\mu$  in size, which is compatible with the size of small viruses and the postulated size of serum hepatitis virus from filtration studies in which human volunteers were inoculated with materials filtered through mem-

branes with various pore sizes. The density of the particles in cesium chloride is approximately 1.2 to 1.21 and this is in the range of densities of other known agents. The particles seen under the electron microscope are virus-like but, to be certain that they are the causative agents of serum hepatitis, a biological activity must be associated with these virus-like particles. With the exception of possible propagation in man, we have not been able to do this with Australia antigen. However, the regular detection of Australia antigen during viremic periods in serum hepatitis and the failure of the appearance of this antigen in liver diseases other than typical serum hepatitis speak for the identification of this antigen as the virus or at least part of the virus of serum hepatitis.

What speaks against Australia antigen as the virus of serum hepatitis? Several groups have tried to demonstrate RNA or DNA in these particles because, with the exception of the slow viruses, all viruses contain either RNA or DNA. In spite of all attempts, no one has been able to show any nucleic acid. But, in itself, this does not mean that it is not there. So far it means only that it has not been found.

Secondly, it is difficult to explain the very high incidence in native or primitive populations. Only more data will help to answer this question. There are discrepancies between the incidence of serum hepatitis and the incidence of this antigen in normal blood donor population, a discrepancy which may be explained because our assay systems are not sensitive enough.

Lastly, some recent data have shown that individuals, after heart operations and multiple blood transfusions, develop very high antibody titer to Australia antigen ten days after the transfusions but, 12 weeks later in the presence of these antibodies, patients developed typical serum hepatitis and did not develop antigenemia. This is difficult to explain and only laboratory data will answer the argument.

Regardless of whether Australia antigen is or is not the agent of serum hepatitis, it is already a well-comed diagnostic tool to distinguish between IH and SH. If Australia antigen is present, then the disease is probably serum hepatitis. And if the presence of this antigen in blood which is to be used for transfusion indicates a higher probability that a recipient would come down with serum hepatitis, this would enable an elimination of some serum hepatitis.

#### Conclusion

This summarizes the present status of hepatitis. With the intriguing demonstration of Australia antigen and the development of marmosets as experimental animal models, we can look for further advances in the near future.



# Laboratory

## Diagnosis of

## Viral Diseases

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Great strides have been made in the laboratory diagnosis of viral diseases since the original isolation of Coxsackie viruses in suckling mice from cases of suspected poliomyelitis in 1947 by Dalldorf and Sickles and the demonstration of viral growth and cytopathogenicity in tissue cultures by Enders and associates in 1948. With the widespread application of tissue-culture technics in the field of virology, approximately 100 new viruses pathogenic for man have been identified in the last ten years. There are only three major diseases of presumed viral etiology for which viruses have not been isolated: viz., infectious hepatitis, serum hepatitis, and leukemias. As more viruses are discovered, the task of classifying and differentiating among them and of establishing their clinical significance becomes more intricate.

Sufficient information concerning the biological, biochemical, and biophysical properties of viruses has been accumulated to permit a tentative grouping of these agents. Animal viruses are placed in eleven major groups based on their nucleic acid composition; there are six RNA-virus groups and five DNA-virus groups as listed below.

### **RNA-Containing Viruses:**

#### **1. Picornaviruses**

##### **A. Enteroviruses**

1. Polioviruses (3 serotypes)

##### **2. Coxsackieviruses group A (23 serotypes)**

##### **3. Coxsackieviruses group B (6 serotypes)**

##### **4. Echoviruses (32 serotypes)**

##### **B. Rhinoviruses (over 100 serotypes)**

##### **C. Unclassified picornaviruses—Encephalomyocarditis, etc.**

##### **2. Reoviruses—Reoviruses types 1, 2, and 3**

##### **3. Myxoviruses**

##### **A. Influenza A, A-1, A-2, B, and C**

##### **B. Paramyxoviruses**

1. Newcastle disease



2. Mumps
3. Parainfluenza types 1-4
4. Respiratory syncytial
5. Rubeola
6. Rubella (?)
4. Coronaviruses—Human infectious bronchitis virus (IBV)
5. Arboviruses
  - A. Group A—Western encephalitis, Eastern encephalitis, etc.
  - B. Group B—St. Louis encephalitis, Dengue fever, yellow fever, etc.
  - C. Group C—Six serotypes (Not found in U.S.A.)
  - D. Complexes—California, Bunyamwera, Cache Valley, etc.
  - E. Ungrouped—Colorado tick fever, Rift Valley fever, Sandfly fever, Epidemic hemorrhagic fever, etc.
6. Rhabdoviruses (Bullet-shaped viruses)
  - A. Rabies virus
  - B. Vesicular stomatitis virus

#### **DNA-Containing Viruses:**

1. Adenoviruses—Adenoviruses of man (30 serotypes)
2. Parvoviruses—Adena-satellite viruses
3. Papovaviruses
  - A. Human papilloma virus (wart)
  - B. Polyoma virus
  - C. Simian vacuolating virus (SV-40)
4. Herpesviruses
  - A. Herpes simplex
  - B. Herpes B
  - C. Varicella-Zoster
  - D. Cytomegaloviruses
  - E. EB virus (Epstein-Barr)—infectious mononucleosis (?)
5. Poxviruses
  - A. Variola
  - B. Vaccinia
  - C. Paravaccinia
  - D. Cowpox
  - E. Molluscum contagiosum

#### **Laboratory Diagnosis**

Improved and expanded laboratory methods have provided evidence that viruses are responsible for a wider range of clinical and pathological conditions than had been previously suspected. For example, it has been shown that subacute sclerosing panencephalitis (a slow virus disease) may be due to the

rubeola virus, and acute myocarditis and pericarditis may be due to certain Coxsackie Group B viruses. It has been suggested that laboratory investigation be employed more extensively to clarify the role of viruses in certain forms of acute and chronic illnesses involving the central nervous system, lungs, liver, gastrointestinal tract, heart, and vessels. It has been demonstrated by laboratory isolation and serologic studies that occasional cases of paralytic disease resembling poliomyelitis may be due to certain ECHO and Coxsackie Group A viruses.

Aseptic meningitis without paralysis, clinically indistinguishable from nonparalytic poliomyelitis, may be due to several different viruses, such as Coxsackie, ECHO, mumps, herpes simplex, herpes zoster, lymphocytic choriomeningitis, and arboviruses.

Similar symptoms may be produced by a variety of viruses and a given virus is capable of producing a variety of clinical syndromes. Thus, on clinical grounds alone it is usually not possible to establish an etiologic diagnosis. A clinical history, therefore, is a useful guide to the laboratory in selecting those procedures which would aid in detecting the variety of viruses associated with the particular clinical syndrome.

Every effort should be made to identify the etiological agent in suspected viral illnesses if we are to have a true picture of the clinical manifestations and incidence of viral infections, especially the incidence of central nervous system diseases, and the effectiveness of immunization.

To establish a laboratory confirmation of viral infection, three methods are employed:

1. Microscopic examination of tissues for inclusion bodies as found in rabies and cytomegalic inclusion disease, or for viral material by the fluorescent antibody technique;
2. Virus isolation from clinical materials by employing tissue cultures, animals, and chick embryos;
3. Serologic tests to demonstrate the appearance and rise in antibody titer.

Whenever possible, the direct isolation of virus from clinical material is the method of choice but should always be accompanied by serologic studies for more accurate interpretation of results.

The types of specimens submitted for virus isolation will depend somewhat on the nature of the illness, but because a wide range of viruses is responsible for similar clinical syndromes it is common practice to include a minimum of specimens in broad disease categories as shown below.

#### **Clinical Specimens for Virus Isolation**

1. **Respiratory Diseases**—Throat swab or throat washings; acute and convalescent serum specimens; postmortem lung



2. **Central Nervous System Diseases**—Throat swab or throat washings; stool specimens; CSF; acute and convalescent serum specimens; postmortem brain and cord

3. **Viral Exanthems**—Throat swab or throat washings; vesicle fluid; stool specimens; acute and convalescent serum specimens

Success in isolating a virus is dependent upon proper collection, storage, and transport of specimens. Unlike bacteria, viruses die out rapidly once they have been separated from host tissues so that it is very important that the virus be kept viable until it can be introduced into a susceptible host system. It is a cardinal principle in virology that the specimen be immediately frozen to maintain potency of the virus unless it can be transported to the virology laboratory within a few hours.

Specimens submitted for virus isolation should be collected during the phase of the illness when they are most likely to contain the virus in high titer. For example, throat washings for the isolation of the respiroviruses should be collected within 48 to 72 hours after onset, whereas polio and other enteroviruses may be isolated frequently from the feces in high titer as late as ten days after onset of meningeal symptoms.

Due to the lability of viruses, specimens for virus isolation should be packed on wet ice and delivered to the laboratory immediately after they are collected. If specimens cannot be delivered promptly, they should be frozen.

The laboratory can best serve the physician in providing meaningful data if the following cardinal rules are observed:

1. Collect specimens for virus isolation early in the course of illness and from proper sources.
2. Freeze the specimens immediately to preserve potency of the virus if specimens cannot be promptly transported to the laboratory.
3. Obtain acute and convalescent sera for demonstrating rise in antibody titer.
4. Submit a summary of the case history to guide the laboratory in selecting the proper methods.

A request for "viral studies" without supporting clinical data is as useless to the laboratory as a flat request for "biochemical studies". It is extremely important to include the clinical diagnosis, provisional clinical diagnosis, or major symptoms such as "upper respiratory illness", "viral pneumonia", "aseptic meningitis", or "exanthematous disease". This information is necessary to guide the laboratory in selecting the proper host systems for virus isolation and the various viral antigens to be used to screen the patient's sera for antibodies.

The success of the laboratory in isolating a virus or in obtaining meaningful serologic data will de-

pend to a great extent on how closely the physician observes these four cardinal rules.

### Interpretation of Laboratory Results

It should be emphasized that the laboratory does not make the diagnosis, but it can provide meaningful data to help support or confirm the physician's clinical observations. The information given below should guide the clinician in his interpretation of laboratory data both on virus isolation and serology.

**Virus Isolation**—Isolation of a virus from clinical material does not establish an etiologic diagnosis *per se*. The significance of such a virus depends upon the source of the isolate. For example, isolation of a virus from the brain in encephalitis or from the spinal fluid in aseptic meningitis provides direct evidence of an etiological association. Isolation of an influenza virus from throat washings of a patient ill with an influenza-like disease strongly suggests that the virus is the causative agent since this virus is only isolated from throat washings in cases of acute influenza. In contrast, the isolation of an enteric virus from the stool of a patient suffering from aseptic meningitis does not by itself indicate an etiological relationship, as enteroviruses are occasionally found in the feces of healthy individuals. Additional supporting evidence is obtained by demonstrating a fourfold rise in antibody titer against the virus isolated.

Failure to isolate a virus from clinical material does not indicate that the suspected viral agent is absent or that the physician's diagnosis can be eliminated. There are many factors which can account for this failure, such as improper time of collection of specimens, improper storage and transport of specimens, or the use of insensitive procedures on the part of laboratory.

Therefore, it is extremely important that acute and convalescent sera (paired sera) be examined to complete the laboratory phase of virus diagnosis by attempting to provide serologic confirmation in the absence of a virus isolation, or to determine the significance of a virus isolated with respect to the current illness.

**Virus Serology**—Serologic tests are those in which the level of antibody in the patient's serum for a particular virus is determined. The tests most frequently employed for this purpose are the neutralization test, complement fixation test, and hemagglutination-inhibition test. In all cases of serologic diagnosis, every attempt should be made to obtain paired sera, an acute *phase* specimen taken as early in the course of disease as possible, and a convalescent phase specimen taken 14 to 21 days later, for demonstrating a rise in antibody titer. Both sera must be tested together in the same batch of tests for the results to be meaningful. A fourfold or greater rise



in the antibody titer usually indicates recent infection with the particular virus. But it is important that all the viral agents commonly associated with a given clinical syndrome be tested with the patient's sera before such data can be considered significant, as serologic cross-reactions and nonspecific anamnestic antibody responses are not uncommon among viruses.

Neutralizing antibody and hemagglutination-inhibition antibody are usually present at onset of illness, or appear within 24 to 48 hours thereafter, and they rapidly increase in titer, reaching peak levels in six to twelve days. If the acute phase serum specimen is not collected within the first few days after onset, it is usually not possible to demonstrate a fourfold rise in antibody titer by the neutralization or hemagglutination-inhibition tests. However, complement fixing antibody does not usually appear until the second week of the illness and does not reach peak titer until about two to four weeks later; therefore,

this test is useful whenever there is a delay in obtaining an acute phase serum specimen.

The antibody titer of a single serum specimen is difficult to interpret, as low levels of antibody for a variety of viruses persist for many years. It is, therefore, not usually possible to determine whether such antibody is the result of a current infection or preexisting antibody from an infection acquired earlier in life.

### Conclusion

As a guide to the physician in submitting specimens for viral studies, the following chart has been included. It lists the common clinical syndromes, viruses which have been associated with each, and the clinical materials which should be collected. Every attempt should be made to obtain all of the materials listed for each illness, since this will greatly increase the chances of the laboratory in establishing an etiologic diagnosis.

### Viral and Related Diseases and Clinical Materials Submitted for Laboratory Diagnosis

ILLNESS	VIRAL OR OTHER AGENT	SPECIMENS TO BE COLLECTED
<b>Respiratory Diseases</b>		
Upper respiratory illness	Parainfluenza Adenoviruses Rhinoviruses Respiratory syncytial Echoviruses Coxsackie A-21 Mycoplasma pneumoniae Reoviruses(?)	Throat washing Stool Paired sera
Exudative tonsillopharyngitis	Adenoviruses EB virus of infectious mononucleosis	Throat washing Stool Paired sera
Acute lymphonodular pharyngitis	Coxsackie A-10	Throat washing Stool Paired sera
Pharyngoconjunctival fever	Adenoviruses	Throat washing Stool Paired sera
Herpangina, stomatitis, or pharyngitis, or all three	Coxsackie Group A Herpes simplex	Throat washing Stool Paired sera Swab of oral lesions
Bronchiolitis	Influenza Parainfluenza Adenoviruses Mycoplasma pneumoniae Respiratory syncytial	Throat washing Stool Paired sera
Laryngotracheobronchitis (croup)	Parainfluenza Influenza Rhinoviruses Respiratory syncytial Adenoviruses Mycoplasma pneumoniae	Throat washing Stool Paired sera



Pneumonia	Respiratory syncytial Adenoviruses Influenza, Parainfluenza Rubeola Varicella Psittacosis Mycoplasma pneumoniae	Throat washing Sputum Acute phase blood Paired sera
Influenza	Influenza A, A-1, A-2, B, C	Throat washing (must be frozen immediately) Paired sera Postmortem lung
Pleurodynia (Bornholm disease)	Coxsackie Group B	Throat washing Stool Paired sera Pleural effusion
<b>Ophthalmic Diseases</b>		
Ocular herpes	Herpes simplex	Eye washing Throat washing Paired sera
Epidemic keratoconjunctivitis	Adenovirus type 8	Eye washing Throat washing Paired sera
Trachoma	Trachoma agent	Eye washing Throat washing Paired sera Tarsus scrapings
Inclusion blenorhea	TRIC agents	Eye washing Throat washing Paired sera Tarsus scrapings
Conjunctivitis	Newcastle disease virus	Eye washing Conjunctival scrapings Paired sera
<b>Exanthematous Diseases</b>		
Herpangina	Coxsackie Group A	Throat washing Stool Vesicle fluid Paired sera
Hand, foot and mouth disease	Coxsackie Group A, types 5, 10, 16	Throat washing Stool Vesicle fluid Paired sera
Chickenpox-Zoster	Varicella	Throat washing Vesicle fluid Paired sera
Herpes simplex	Herpes simplex	Vesicle fluid Throat washing
Vaccinia-Smallpox	Vaccinia, Variola	Vesicle fluid Throat washing Acute phase clotted blood Paired sera Postmortem liver and spleen
Dengue fever	Dengue virus types 1-4	Acute phase clotted blood Paired sera



Nonspecific febrile illness with rash	Echoviruses Coxsackie Group A Coxsackie Group B	Throat washing Stool Paired sera
Erythema infectiosa	Unknown	—
Exanthem subitum (Roseola infantum)	Unknown	—
Genitourinary Tract Infections		
Viruria	Echoviruses Coxsackie Group B Adenoviruses Mumps Cytomegalovirus Rubeola Rubella Vaccinia Herpes simplex	Urine Paired blood
Vulvovaginitis	Coxsackie Group B Herpes simplex Lymphogranuloma venereum	Vaginal swab Lesion scraping Paired blood
Central Nervous System Diseases		
Paralytic disease	Poliovirus types 1, 2, 3 Coxsackie A-7, A-9 ECHO types 2 and 9	Throat washing Stool Cerebrospinal fluid Paired sera Postmortem brain and cord
Aseptic meningitis	Poliovirus Coxsackie Groups A and B ECHO viruses Herpes simplex Mumps Lymphocytic choriomeningitis Lymphogranuloma venereum Psittacosis	Throat washing Stool Cerebrospinal fluid Paired sera Postmortem brain and cord
Guillian-Barre syndrome	Coxsackie Group A ECHO viruses	Throat washing Stool Cerebrospinal fluid Paired sera Postmortem brain and cord
Meningoencephalitis	Western encephalitis Eastern encephalitis St. Louis encephalitis California encephalitis Mumps Measles	Throat washing Stool Cerebrospinal fluid Paired sera Postmortem brain and cord Acute phase clotted blood for isolating encephalitis viruses
Subacute sclerosing panencephalitis (Dawson's encephalitis)	Rubeola	CSF Blood Postmortem brain
Toxic encephalopathy (Reye's Syndrome)	Unknown	Throat swab Stool Blood Postmortem liver, spleen, lung, brain, intestinal contents, blood



Cardiovascular Diseases		
Myocarditis and pericarditis	Coxsackie Group B	Throat washing Stool Paired sera Postmortem heart
Miscellaneous Diseases		
Cytomegalic inclusion disease	Cytomegalovirus	Saliva Urine Paired sera
Mumps	Mumps	Urine Throat washing Paired sera
Orchitis and epididymitis	Mumps Coxsackie B	Urine Throat washing Paired sera Stool
Intussusception	Adenoviruses	Stool Mesenteric lymph node Paired sera
Lymphogranuloma venereum	LGV agent	Lesion fluid and pus
Colorado tick fever	CFT virus	Acute phase clotted blood Paired sera
Infantile diarrhea (Enteritis)	Echoviruses Coxsackie Group B	Throat washing Stool Paired sera
Nonspecific febrile illness	Polio Coxsackie Groups A and B Echoviruses	Throat washing Stool Paired sera
Postperfusion syndrome	Cytomegalovirus EB virus	Acute phase blood Paired sera
Acute infectious lymphocytosis	Coxsackie-like virus EB virus	Throat washing Paired sera
Gastroenteritis (Winter vomiting disease)	Unknown	—
Rickettsial Diseases		
Rocky Mountain spotted fever	Rickettsia rickettsii	Acute phase clotted blood Paired sera Postmortem liver and spleen
Epidemic typhus Murine typhus	Rickettsia prowazeki Rickettsia typhi	Acute phase clotted blood Paired sera Postmortem liver and spleen
Q-fever	Coxiella burnetii	Sputum Urine CSF Acute phase clotted blood Postmortem liver and spleen
Rickettsialpox	Rickettsia akari	Acute phase clotted blood Paired sera Postmortem liver and spleen

*Bibliography will be supplied on request*



Viral interference is the ability of one virus, either active or inactive, to suppress the replication of another which is related or unrelated serologically to the inhibiting virus. Isaacs and Lindemann showed that interference was, in many cases, due to a humoral substance which was released into the body fluids or into the tissue culture medium.

# Antiviral Agents

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So, interferons can be defined as a group of antiviral proteins which are produced by cells in response to virus infection or exposure to some non-viral substances. Treatment with an interferon confers upon cells resistance to multiplication of a wide variety of viruses. Interferons seem to act through cells and not directly on viruses; thus, they differ in many respects from antibodies, which act directly on viruses and not through a cellular mechanism.

The great value of the discovery of the interference mechanism made by Isaacs and Lindemann is manifest. First of all, it explained many cases of viral interference. Secondly, it involves what is probably a natural resistance mechanism, although it may not be the only natural resistance mechanism.

Thirdly, and perhaps most importantly, the discovery of interferon gave hope that a general prophylactic and treatment agent would be possible for viral infections. That agent may not be interferon, but the fact that there is something that can treat cells and make them resistant to a wide variety of viruses is very encouraging.

A fourth implication of their findings is that there is some difference between the virus replication mechanism and the physiology of the cell. In other words, the cell can be rendered resistant to virus replication.

And finally, interferon production and response to interferon seem to be general biologic reactions: An interferon, or something similar to it, has been demonstrated in a wide variety of animals, from fish to primates.

The outstanding property of interferons is that they inhibit the growth of a wide variety of both DNA and RNA viruses. Interferons have one peculiar property—they are generally species-specific. That is, interferon produced in one animal species usually has little or no activity in other species. For example, chicken interferon will not protect mouse cells, although it will protect chicken cells. Likewise, mouse interferon will not protect chicken cells. However, mouse interferon will protect the cells of hamsters, which are fairly similar, but the protection

will not be as effective as it will be against mouse cells.

Early in the game, it was discovered that human interferon is active on simian cells. Very recently, it was found that human interferon is active on rabbit cells, but, in general, species specificity holds up.

Interferons are antigenically distinct from viruses. Antiviral antibody has no direct relationship to interferon, and interferon does not neutralize viruses out of the cell as does antiviral antibody. Interferon itself was originally considered to be a poor antigen; that is, antibodies to interferon were difficult to produce and an anti-interferon antiserum is very difficult to obtain. It is probably incorrect to say that interferon is a poor antigen; it is just a very powerful biologic substance, and highly active preparations of interferon contain very little interferon. While one might be dealing with thousands of units of interferon, one unit has very little protein.

Concerning the chemical and physical properties of interferons, they are a group of molecules with varying molecular weights, even within the same animal species or in the same production batch. One type of interferon varies in molecular weight from about 20,000 to 40,000. These are usually induced by viruses. Interferons with molecular weights well over 50,000 have been induced by other substances such as bacterial endotoxin.

Interferon is a protein and, thus, is sensitive to proteolytic enzymes. It may contain a polysaccharide component. Interferon is stable to a very wide pH range, from about pH 2, to at least pH 10.

Different interferons have different heat stability. Human interferon is partially stable at 56 degrees and is destroyed at 65 degrees, but interferons of some other animal species are quite stable at 65 degrees.

In general, interferons should be proteins with the aforementioned pH and heat stability. They should show some degree of species specificity. Finally, interferons should act not directly on virus but through a cellular mechanism.

In one type of assay reduction in virus plaque,



number is studied. Other methods have been used. Inhibition of cytopathic effect is one of the oldest assay methods. One can assay more directly for the reduction in the total yield of virus or look for a specific reduction in the production of a virus product. The latter is an assay that has not been too frequently used, but was the original method that Isaacs and Lindemann discovered interferon with.

Finally, work is now in progress on the possibility of using a complement fixation or radioimmuno assay for interferon. For these, one needs purified interferon.

One unit of interferon is usually defined as that amount of interferon which will inhibit virus growth by 50% or, in some laboratories, somewhat more than 50%. In other words, one unit will inhibit virus growth by a certain defined amount. A total purification of interferon has not yet been achieved. So far, the best preparation made is a chick interferon which has been found to contain 1,600,000 units per milligram of protein. However, to the dismay of those who carried out this purification, when the specimen they had was analyzed by electrophoresis on acrylamide gels, it was found that not one but two bands were present. When they sliced the gel and tested the different areas for antiviral activity, they found the antiviral activity band did not correspond to either of the two visible bands. In other words, the amount of activity in the interferon they purified was considerably more than 1,600,000 units of interferon per milligram of protein, but there was so little active interferon in their preparation that they could not see it as a stained band.

Extrapolating from their work, it seems that very few molecules of interferon are necessary to protect a cell. This is only a theoretical analysis based on certain assumptions.

Not much success has been attained in purifying other interferons. A major effort to purify human interferon is now in progress. The chick interferon preparation, discouraging as the results with it are, is still the best we have.

### Producing Interferons

Interferon production can be induced by virus infection. In a typical growth curve of a virus in tissue culture, the production of interferon often follows the end of the logarithmic phase of virus growth and reaches an end point well after virus has attained its maximum titer. This is one type of response, but there are many variations.

Viruses differ in their capacity to induce interferon production. Often, attenuated viruses are good inducers of interferon (as opposed to virulent strains) so the capacity to induce interferon pro-

duction may be one trait related to attenuation of viruses.

The chemical unit of the virus which induced interferon production is not known. Since simple viruses such as the enteroviruses (which consist only of viral RNA with a protein coat) can induce interferon, it follows that at least in the case of those viruses, the element which induces interferon must be viral RNA or viral protein, or both. Since it has been shown that one can induce interferon production with a highly structured, synthetic, double-stranded RNA, it is likely that RNA is the crucial element.

Not only factors related to the virus figure in the ability to produce interferon. There are also many cellular factors. For instance, the type of cell is important. A mixture of human white-blood cells can produce very high titers of interferon, but only the lymphocytes in the white-cell mixture seem responsible for interferon production. Also, the metabolic state of cells is important. Cells with high metabolic rates very often are poor producers of interferon.

Cellular protein synthesis is often necessary for interferon production. This has been shown, directly and indirectly, by many experiments. For instance, treating the cells with an analogue of an amino acid greatly lowers their capacity to produce interferon. However, analysis of this procedure has suggested that there may be more than one protein necessary for interferon production. One of these proteins would be interferon; perhaps some other cellular product such as an enzyme is also necessary. Interferon production is also usually blocked by actinomycin D, a potent inhibitor of cellular RNA synthesis, indicating that cellular RNA synthesis is also required for interferon production.

Interferon production, therefore, follows many of the rules associated with induced protein synthesis, a process which has been studied very vigorously in bacteria.

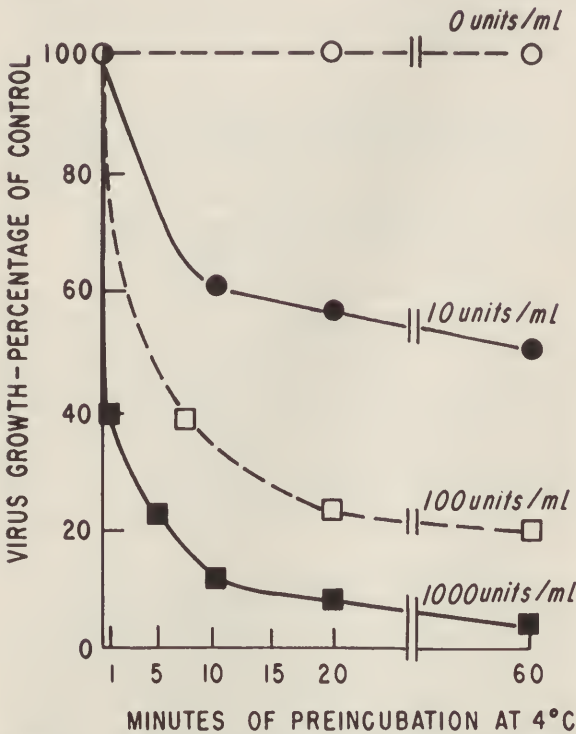
Recent work has shown that there are cases where interferon can be produced in the presence of inhibitors of protein and RNA synthesis. This may involve situations where there is preformed interferon or perhaps something similar to an interferon precursor.

Very little is known about how interferon works. However, it seems to work in two steps. First of all, interferon treatment of the cells renders them resistant to viruses. The ability to render the cells resistant depends on certain metabolic events which must happen in the cell. The second consideration is the effect the interferon treatment has on the virus. What events in the virus replication cycle are blocked as a consequence of the changes that interferon brings about in this cell?

The first step in interferon action, like the action



of many relatively low molecular weight, active polypeptides, would seem to be binding to the cell (Figure 1).



**Figure 1: Interferon binding:** chick cells were incubated at 1 C with the indicated concentration of interferon for the indicated time period. They were then washed with cold medium and incubated at 37 C for two hours and finally infected with virus. The virus growth in the cells was titred and plotted as a percentage of untreated values.

Cells were incubated with 10, 100, or 1000 units of interferon in the cold for different lengths of

time. Then the interferon was washed off and the amount of antiviral activity was measured by how well it resisted virus infection.

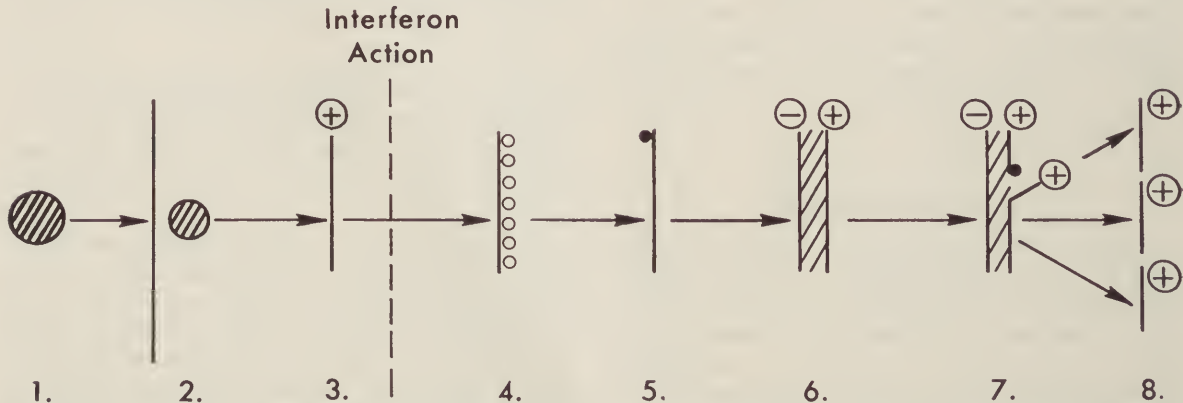
With different amounts of interferon, one sees different levels of resistance to virus infection, but after about ten minutes, resistance never significantly increases. This suggests that there is a binding of interferon to the cell and that this is an equilibrium reaction dependent on the concentration of interferon in the solution.

A further related finding is that no antiviral activity develops at all if the cells are left in the cold and treated with trypsin (a proteolytic enzyme which will destroy interferon). This suggests that the interferon is actually bound to the outside of the cell.

Trying to measure the amount of interferon that is bound is very difficult. It is so small that one cannot measure its disappearance from solution. This is certainly not unique. When using the same techniques with small polypeptide hormones such as thyroid-stimulating hormones or ACTH, one also finds the binding of very small amounts of the hormone to the specific target cells.

The amount of interferon that can be bound has actually been shown to be less than 7% of the input interferon. It takes very little interferon, in the right place, to cause antiviral activity to develop.

Figure 2 shows the early steps in the growth mechanism of RNA viruses. Extracellular virus, step 2, gets into the cell. Its protein coat is removed, and this releases the viral RNA (step 3). The viral RNA associates with the ribosomes of the cell (step 4) to form a polyribosome, an event which results in the production of an enzyme which is necessary to make viral RNA (step 5). This enzyme produces a double-stranded, base-paired form of viral RNA (step 6). The double-stranded helix then produces progeny virus (steps 7 and 8).



**Figure 2: Growth of an RNA virus showing early steps in the mechanism of growth of a single-stranded RNA virus**

Now where does interferon act to inhibit this basic replication mechanism? It was shown very early

that it could not act before step 3, simply by showing that interferon could inhibit the infection of cells



with the uncoated infectious RNA. Furthermore, it was shown that interferon inhibited the production of progeny viral RNA (step 8). So, somewhere between steps 3 and 8, interferon must act.

Steps 6 and 7 are also inhibited: The formation of the base-paired RNA does not take place. Therefore, interferon must act between steps 3 and 5.

In experiments performed by infecting with radioactive virus, it was shown that a ribonuclease-resistant, double-stranded form of RNA is formed in control cells very soon after infection. In the presence of interferon, as is the case with antimetabolites such as puromycin that nonspecifically inhibit protein synthesis, none of the radioactive double-stranded RNA is formed.

In the infected cell, under conditions where very little viral RNA can be produced, an experiment was performed to determine whether virus protein synthesis was inhibited in interferon-treated cells. In the control cells that were not treated with interferon, a group of proteins were separated on acrylamide

gels. These proteins were virus-specific. In the interferon-treated cell, only one protein was found, corresponding in migration to the most common protein found in the uninfected cell. Perhaps this is a cellular protein. The important point is that under conditions where the virus RNA cannot replicate (so that only proteins produced on the incoming strand of virus are probably being made), virus proteins in interferon-treated cells do not seem to be produced at all, or seem to be produced very poorly at best.

Life for DNA viruses is somewhat more complicated than for RNA viruses (Figure 3). In the early steps of vaccinia virus replication, the virus enters the cell, and the outer coat is removed (step 3). A core of virus remains from which virus messenger RNA is produced (step 5). This associates to form protein-synthesizing polyribosomes (step 6) which make virus proteins (step 7), one of which eventually frees the virus DNA from its coat (step 9). Then the virus DNA goes on to make DNA, RNA, and viral protein.

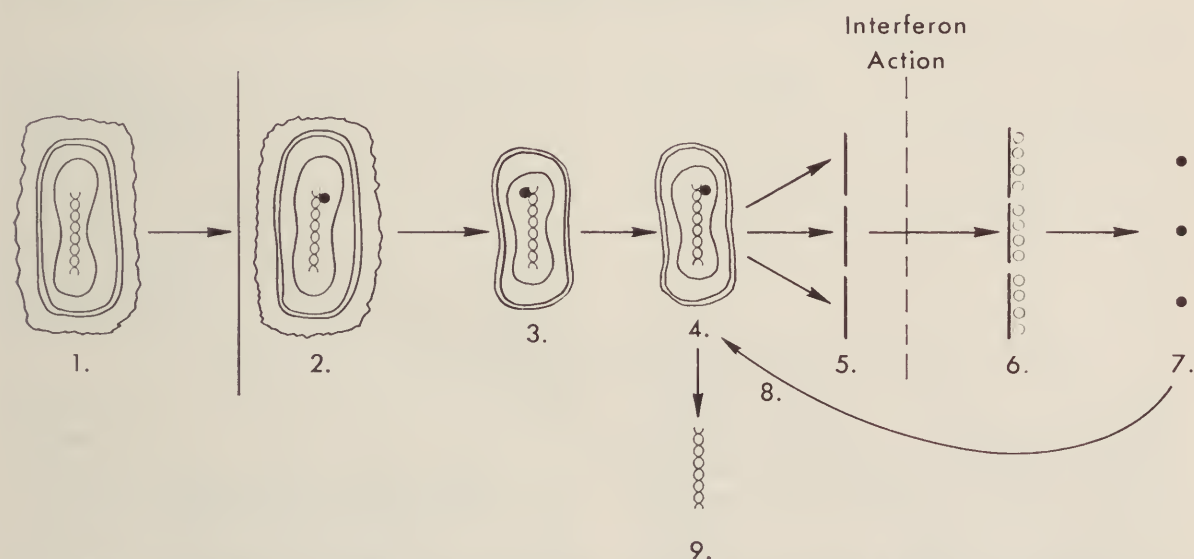


Figure 3: Growth of vaccinia virus showing early steps in the mechanism of growth of vaccinia virus

The mechanism of action of interferon in this system has been very carefully investigated; interferon has been found to inhibit the formation of virus-specific polyribosomes, although viral messenger RNA is formed. Consequently, the virus is never completely uncoated because the viral enzyme which causes uncoating is not formed. Therefore, in the interferon-treated cell, the virus stays in this incompletely uncoated state and virus messenger RNA floats freely around the cytoplasm but never associates with the ribosomes.

The conclusion is that the action of interferon appears to be related to initiation of virus protein synthesis. There are some confusing data from studies of cell-free systems. These studies claim that the ribosome is the site of action of interferon. But

there are contradictory findings.

A great deal of understanding of protein synthesis has developed recently, mostly in bacterial systems to be sure, but many laboratories are now working on cell-free protein synthesizing systems using animal cells and viruses. Eventually, these will probably be used to study the action of interferon.

### Virus Infections

Experiments certainly show that some real difference must exist between the virus and the cell in how protein synthesis is initiated, because interferon treatment can distinguish between these. In an interferon-treated cell, cellular protein synthesis goes on very well, but the protein synthesis of a virus is greatly inhibited. How interferon action is modified



by several treatments also is an important part in the study of how it acts on the cell. Interferon action has been shown to be inhibited by compounds which impair cellular RNA or protein synthesis. The results of these studies indicate that cellular RNA and protein synthesis are probably necessary for interferon action.

Figure 4 summarizes. Interferon is bound to the

cell membrane and is susceptible to destruction by trypsin (1). Perhaps some interferon then gets into the cell, but nobody has conclusively shown this to be true. Cellular RNA synthesis is required. This can be blocked by actinomycin D (2). Cellular protein synthesis is also required (3). Presumably, the protein produced is an antiviral protein. Somehow, this works to inhibit virus protein synthesis.

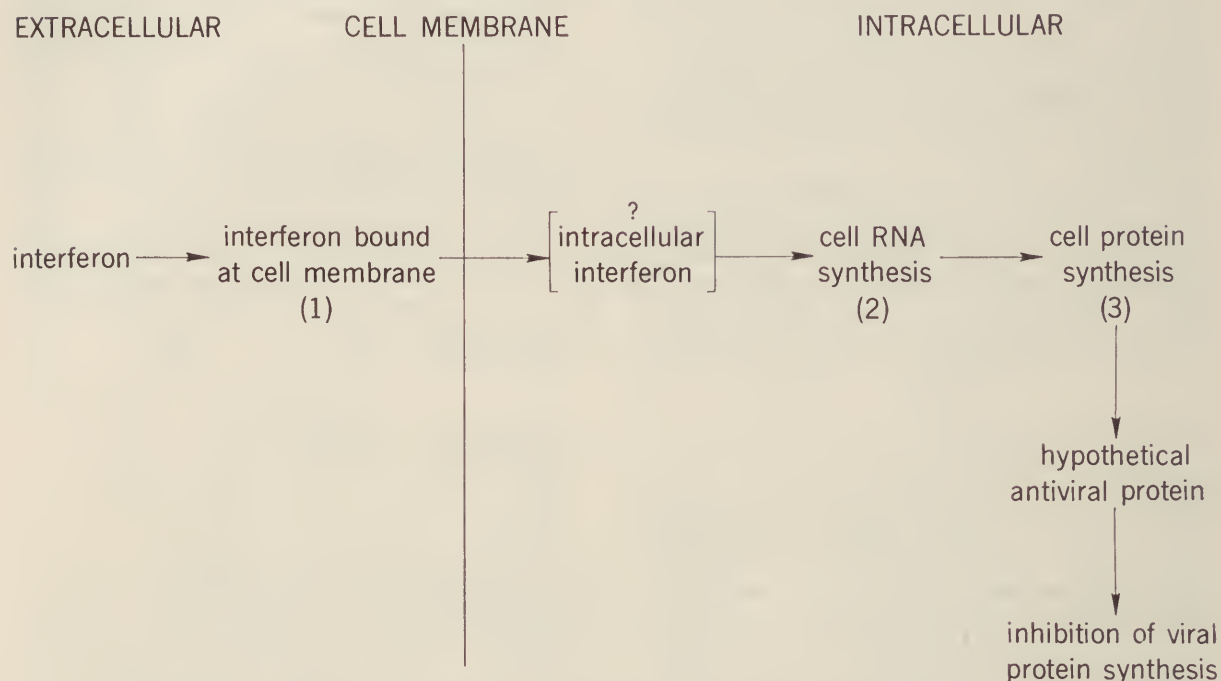


Figure 4: Mechanism of action of interferon—an interpretation based on several studies

One important question is whether interferon is an inhibitor of natural virus infection. Interferon is produced in response to virus infection and may be an important defense mechanism. Factors that might be responsible for recovery from virus diseases include circulating antibody, natural virus inhibitors, local antibody, delayed hypersensitivity, or interferon.

Antibody is specific. We know we can transfer immunity to viruses only by transfer of specific antibody. We can also stimulate immunity to virus infection by stimulating only specific antibody production. Inhibition of antibody response results in inhibition of recovery. Antilymphocyte serum also results in inhibition of recovery. This seems to indicate that antibody is very important in recovery. Antibody is certainly important in preventing secondary virus infections. Thus, it is a key factor in defense against virus infections. However, how important is it in recovery from primary virus infections, and does interferon have a role in this process?

Many investigators have noted that a nonspecific resistance develops to new virus infections during the course of recovery. Also, agammaglobulinemics in general have been vaccinated, get colds and many

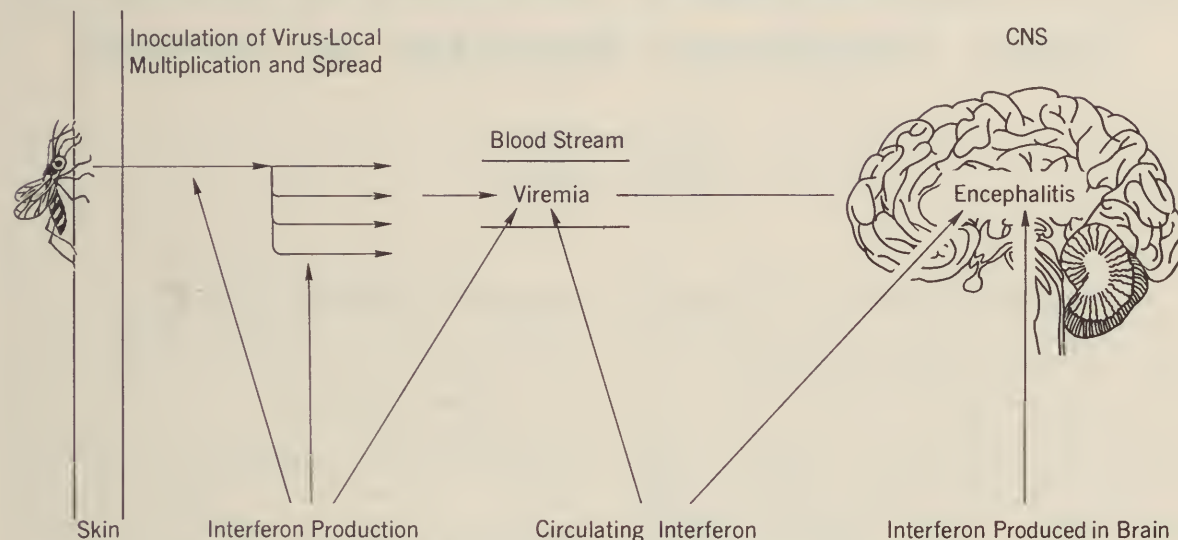
virus infections, yet seem to recover as well as people who have normal levels of gamma globulin. Many experiments have been conducted in animals where immune responses were inhibited. In guinea pigs, whose immune responses were seriously inhibited by methotrexate and X-radiation, the fall-off in virus present in a vaccinia skin lesion is just as rapid as in the skin of animals with unimpaired immune responses. The production of interferon in the treated animals was not depressed.

Experiments like these suggest that interferon is produced under conditions where immune responses cannot be too important in recovery because one cannot measure them. Other evidence shows that during viremia caused by some viruses, interferon appears in the blood, an interferonemia. Interferonemia is very well correlated with the viremia. Since interferon is a very small molecule, one can assume it diffuses in and out of tissues a lot faster than a virus. So, interferon might be important as a recovery mechanism in certain types of infection. For instance, in an infection with an arbovirus (Figure 5), virus grows at the site of introduction. The virus has to go through the



circulation to reach the brain. It could be that local interferon production or production stimu-

lated by the viremia might protect the central nervous system against infection.



**Figure 5: Interferon action in an arbovirus infection**

Interferon may also bear a relationship to viral tumorigenesis. It has been shown that interferon can inhibit the growth of both RNA and DNA tumor viruses. Interferon also inhibits production of tumor-specific antigens by tumor virus and morphologic transformation of cells caused by tumor viruses. Very recently, Hilton Levy, from the National Institutes of Health, showed that double-stranded RNA (an inducer of interferon) can inhibit the growth of some animal tumors. Whether or not this is through the mechanism of production of interferon is questionable. Therefore, tumor viruses, and perhaps tumors themselves, are sensitive to interferon treatment.

#### **Possible Therapeutic Uses of Interferon and Interferon Inducers**

Under certain specific conditions, interferon can be shown to inhibit the morbidity and mortality following virus infection. Interferon also inhibits vaccinia growth in human beings, and the development of ocular vaccinia following mass inoculation. It has recently been shown that a double-stranded RNA interferon inducer was an effective agent in aiding the healing of ocular herpes infection in rabbits.

There are several problems related to the possible therapeutic use of interferon. First of all, there is species specificity. In human beings, human interferon is needed. One solution to this problem may be to use an inducer of interferon—something such as double-stranded RNA that will induce very high titers of interferon. Another solution is to find some active moiety in the interferon molecule, or an animal interferon which crosses with human tissue. Right now, there is real interest in inducers of inter-

feron as perhaps being a general method of treatment of virus infections.

Another problem is the time of administration. If interferon is given after infection develops, how useful is it going to be? It will probably not be very useful in the treatment of something like an acute viral encephalitis. On the other hand, interferon may be quite important in treating chronic viral diseases. It may find use in treatment of herpes zoster, rabies, or a slowly developing chronic encephalitis. It may help in the slow recovery from respiratory infection. The trouble is that we must know that a person is ill before we can start to treat him. Since interferon requires certain steps on the part of the cell to be effective, the treatment may always be a little late once the disease has started.

Interferon or an interferon inducer might certainly be useful as a prophylactic agent for people exposed to infection or for general use during an epidemic when large groups are likely to be exposed.

Right now, there is a controversy between people who want to use inducers of interferon and the so-called purists—those who want to purify human interferon and use it as such.

There are studies in progress in humans on the use of interferon and interferon inducers in respiratory diseases. Also, interferon inducers are being used to treat tumors in humans. The results of these studies should be very interesting to the medical and the general public. Perhaps the age when interferon or interferon inducers might directly be useful is near. Perhaps interferon will point the way to other antiviral substances which will have a wide spectrum of action and are generally useful in inhibiting virus infections.



# **your medical faculty at work**

**by John Sargeant**

**Executive Director**

**The Executive Committee met on February 25, 1971, and took the following actions:**

1. Approved the Faculty's regular contribution to the Student American Medical Association and the Maryland League for Nursing;
2. Heard that plans are under consideration to establish a memorial lectureship in memory of Grant E. Ward, MD;
3. Heard that discussions are under way towards the Faculty assuming all operations of the MEDIC Network, with the State Health Department entering into a contract with the Faculty to do this;
4. Requested the Bylaws Committee to prepare an appropriate bylaws change to directly permit the granting of Emeritus Membership to members who are no longer affiliated with a component society;
5. Took a position in opposition to corporal punishment in the public school system, by whatever name it is called, such as "paddling";
6. Submitted the names of three physical therapists to the Secretary of the Department of Health and Mental Hygiene for selection of one for appointment to the Board of Physical Therapy Examiners;
7. Requested component societies to submit a list of nominees for consideration of the Faculty. From these nominees, a list will be prepared for submission to the Secretary of Health and Mental Hygiene for appointment to the Commission on Medical Discipline;
8. Submitted a similar list of three names for appointment to the Advisory Council on Hospital Licensing by the Secretary of Health and Mental Hygiene;
9. Submitted several names to the Commissioner of the Department of Motor Vehicles for appointment to the Medical Advisory Boards;
10. Heard that both Blue Cross and Blue Shield have asked the Hospital Cost Analysis Service to make a study of the contractual arrangements between hospitals and physicians and the effect they may have on the cost and availability of certain services used by members of both Blue Cross and Blue Shield. The Executive Committee advised it was willing to discuss this data when such information was available;
11. Requested the Bylaws Committee to prepare an appropriate bylaws amendment to provide for a \$20 increase in annual dues for active members;
12. Requested the Editorial Board to study Journal operations and the current deficit;
13. Authorized expenditure of funds for painting the Faculty building, both inside and outside;
14. Expressed grave concern over the use of the term "commitment to a total health care system" by the Regional Planning Council for Prince George's County, in deferring action on a hospital license, and asked for clarification;
15. Expressed interest in the certification requirements of teachers of health occupations;
16. Endorsed the concept that half-way houses for alcoholics be licensed to qualify for payments under health insurance, thus releasing higher cost hospital bed facilities;
17. At the request of the D.C. Society, requested Maryland's two U. S. senators to sponsor legislation dealing with confidentiality of medical society hospital staff records in the district;
18. Authorized attendance of a Faculty representative at a national conference on peer review in Chicago, May 21 and 22, 1971.



# American Association of Medical Assistants

The installation of officers of the newly formed American Association of Medical Assistants, State of Maryland, Anne Arundel County Chapter, was recently held in the Chesapeake Room of the Anne Arundel General Hospital. This new association is sponsored by the American Medical Association and the Anne Arundel County Medical Society.

The purpose of this association is to cooperate with the medical profession in improving public relations, inspire its members to render honest, loyal, and more efficient service to the profession and to the public which they serve, offer educational services for self-improvement of its members, and stimulate a feeling of fellowship and cooperation among the societies.

There are presently 37 members in the new association. Membership is encouraged by all medical assistants working in Anne Arundel County.

A candlelight ceremony was performed by Mrs. Jean Subock, president of the American Association of Medical Assistants, who installed the following officers: Mrs. Ruth Schumacher, President; Dorothy Thomas, President-elect; Joan Sears, Recording Secretary; Jane Ure, Corresponding Secretary; and Sandra Wilson, Treasurer.

Stephen B. Hiltabiddle, MD, and Robert W. Frazier, MD, were duly elected and accepted as advisors to this association for a two-year term.

Heading the committees are: Jean Subock, Program; Patricia Kalnoske, State Representative; Mary Lou Connell, Membership; Sarah Gilden, Public Relations; Virginia Carpenter, Arrangements; Sue Lewis, Nominating; Dorothy Thomas, Constitution and Bylaws; Jean Atkinson, Audit; Kay Elliott, Elections; Mary Shimer, Education; Sandra Wilson, Budget and Finance; and Irene Spriggs, Registration.

Meetings are held on the second Thursday of every month at the Anne Arundel General or the North Arundel Hospital at 8 PM.

Charter members of the association include: Jean Subock, Patricia Kalnoske, Anne North, Irene Spriggs, Ruth Schumacher, Sarah Gilden, Mary Lou Connell, Betty Pruett, Virginia Carpenter, Sue Lewis, Jane Ure, Dorothy Thomas, Maureen Donaldson, Siretta Riley, Lois Deale, Jean Atkinson, Doris Burkman, Josephine Conner, Cindy Dawson, Lois Drauin, Kay Elliott, Jan Featherstone, Betsy Franch, Charlene Fowler, Alma Jewell, Dorothy Kennedy, Irene Laitinen, Del Marsh, Kay Pearce, Anne Pittman, Mary Shimer, Judy Trott, Kathleen Tolliver, Phyllis Tolliver, Linda Womack, Sandra Wilson, and Joan Sears.

\* \* \*

The Baltimore Chapter of AAMA met in Towson at the Penn Hotel on January 12, 1971. The usual cocktail hour and dinner was followed by a lecture on adolescent problems of behavior by Dr. Hyman S. Rubenstein. A business meeting concluded the session.

Dr. Rubenstein—neurologist, psychiatrist, and psychoanalyst—received his MD degree from the University of Maryland School of Medicine in 1928 and his PhD degree from the University of Maryland Graduate School in 1934. His graduate studies included work in endocrinology and neurology (University of Maryland), and psychiatry (Henry Phipps Psychiatric Clinic of The Johns Hopkins). He was certified by the specialty boards in both neurology and psychiatry in 1936.

From 1935 to 1951, Dr. Rubenstein served as Director at the Sinai Hospital, first of neuroendocrine research and then of neuropsychiatric research. He has published over 70 scientific papers and is the author of two technical books on the brain and central nervous system.

His talk on adolescent problems was most interesting to those members with teen-age children. Those who were unable to attend the meeting certainly missed a very rewarding evening.

\* \* \*

Two important dates to remember—**May 9-15** is **Maryland Medical Assistant's Week**, as proclaimed by Governor Marvin Mandel; **May 15** is the **state meeting** of the Maryland Association of Medical Assistants at the Penn Hotel in Towson. Registration for the state meeting will be held at 10 AM, followed by a business meeting at 10:30 AM. An educational seminar at 2 PM will feature Russell Fisher, MD, of the Medical Examiner's Office, and Mr. Frederick Schmuff, from the Probations Department of the State of Maryland. The topic will be violence.

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**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine:** Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

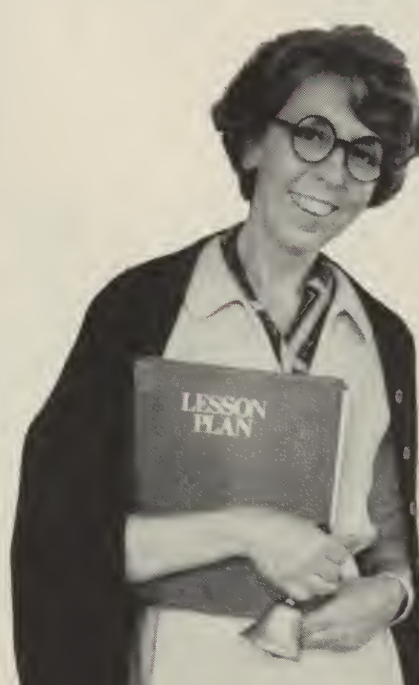
**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

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MRS. ROBERT W. GARIS, EDITOR

## woman's auxiliary

# Annual Meeting News

The Annual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty will be held in Baltimore on May 12 and 13 at the Hilton Hotel on Fayette Street and the Civic Center next door. The entrance is on Hopkins Place. There will be room for everyone and everything this year, plus plenty of parking in the Hilton underground garage and others nearby.

The Civic Center will have ample room for the exhibits in the hobby show. Take time to see the art and hobby exhibits that will be housed there. Please fill in the slip you received with your program so that sufficient space will be provided for your use.

Between sessions of the meeting will be a good time to meet and greet old friends, and to make new ones.

The park and benches in the New Charles Center, amid the boutique shops with their luscious wares, will be beckoning. A mere two or three blocks away are the old standby department stores, where old favorites of all descriptions may be found. The restaurants in the area have food for every taste at prices to suit every pocketbook.

Breakfast Week (May 9 through 16) will feature special activities to please every family member.

Plan to come early on Wednesday, May 12, for that is Flower Mart Day in Baltimore. This year, the mart will be located in the Center Plaza around the beautiful fountain donated by Mr. and Mrs. Jacob France. The plaza is just behind the hotel and in front of the Mechanic Theatre. This is the day when all the garden clubs of Baltimore hold a sale for the benefit of Baltimore Civic League Projects. There will be beautiful flowers and plants, crab cakes to munch, hot dogs on rolls, and the famous lemons and peppermint sticks. Bring your camera—first for the convention pictures that you and the

members of your auxiliary will treasure, and also for pictures of this most colorful Baltimore Ladies' Event.

The Convention Program will feature Mrs. Willard C. Scrivner, First Vice-President of the Woman's Auxiliary to the AMA.

The Rev. Richard K. Young, DD, will be the speaker at the luncheon on May 13 at 12:30 PM. He will speak on "Human Relations". Dr. Young was the former director of the School of Pastoral Care, Bowman Gray School of Medicine in Winston Salem, North Carolina. He is now associated with the Southeast Baptist Seminary in Wake Forest, North Carolina. Make your luncheon reservations for this outstanding event with Mrs. Arlie Mansberger at 4001 Crescent Road in Ellicott City, Maryland 21043.

Our Auxiliary President, Mrs. Raymond M. Yow, has graciously offered the president's parlor to those looking for a spot for a private chat or for a few minutes of relaxation.

Registration for the meeting will be handled by Mrs. Charles H. Williams (Chairman), Mrs. Raymond Cunningham, Mrs. Irene Bauersfeld, and Mrs. W. Walter Hammett. Mrs. Howard F. Raskin will be at the credential desk.

Mrs. James L. Garey will be in charge of the hostesses. Several of the following auxiliary members will be on hand at all times to greet you and to answer your questions:

Mrs. Roger G. Windsor, Mrs. Otto C. Brantigan, Mrs. Dudley Phillips, Mrs. Gerald C. Palmer, Mrs. Elliott C. Flick, Mrs. Max R. English, Mrs. H. Leonard Warren, Mrs. Philip W. Heuman, Mrs. Wallace H. Sadowsky, Mrs. Peter P. Rodman, Mrs. Frank E. Poole, Mrs. Robert W. Garis, Mrs. Jesse C. Coggins, Mrs. Ferd E. Kaden, Mrs. Archie R. Cohen, and Mrs. William S. Stone.



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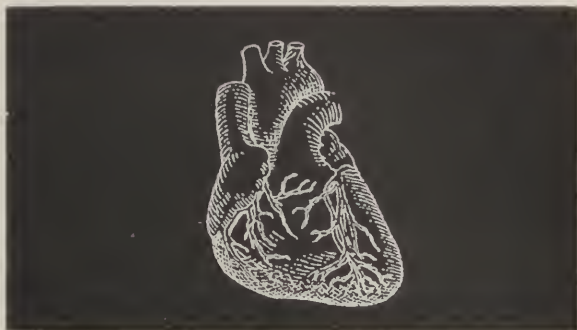
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MIRIAM L. COHEN, MD, EDITOR

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## the heart page

# Homograft Heart Valves

**JOSEPH S. MC LAUGHLIN, MD**  
Head, Division of Thoracic Surgery  
University of Maryland School of Medicine  
Baltimore

**JAMES BLACKFORD, MD**  
Resident in Thoracic Surgery  
University of Maryland School of Medicine  
Baltimore

Homograft heart valves have been used for over ten years, ever since Murray, in Toronto, placed a homograft aortic valve in the descending thoracic aorta of a patient with aortic incompetence. Subsequently, Gunning and Duran at Oxford suggested that aortic homografts could be placed in the sub-coronary position. Ross in London and Barrett-Boyes in New Zealand developed this technique, and their present experience approximates one thousand cases of aortic and mitral valve replacement with homograft aortic valves.

In this country, homografts have not been so widely used, but Malm in New York and Kirkland and McGoon at the Mayo Clinic have reported on fairly large series, and Weldon and others have modified homograft techniques for application to congenital absence or atresia of the pulmonary artery.

The valves are obtained at autopsy, preferably from young women. The entire aortic root is removed, trimmed of excess muscle, and X-rayed to rule out the presence of calcium deposits. The best method for sterilization and preservation is controversial, but gamma ray sterilization, introduced by Gibbon and Alladine in London, and storage in sealed plastic bags at  $-70^{\circ}\text{C}$  appears to be the most effective technique and is associated with the least number of side effects. Valves have been stored for as long as one year before insertion with satisfactory performance but most are used within a few months. Classification of valve size is on a rough scale of 1-4, from small to large normal adult.

The valves are inserted during cardiopulmonary bypass, conducted in the usual manner for artificial valve placement. The aorta is opened just above the

sinus of Valsalva area, the diseased valve is excised, and any calcium deposits in the valve area are rongeuired away. An appropriate size homograft valve is selected and sutured into the aortic root below the coronary arteries. Technically, this is tedious and more time-consuming than insertion of a fixed frame prosthesis, but is not particularly difficult. For mitral and tricuspid valve replacement, homograft aortic valves, sutured to various frames for support, have been used and are inserted in the mitral or tricuspid position by precisely the same technique used for any fixed frame prosthesis. The initial operative mortality and morbidity for homograft valve insertion is the same as that generally found in prosthetic valve surgery.

There are two major advantages to using homografts. The first is the low cost—which has made this technique particularly appealing in less wealthy areas of the world. The second is the virtual freedom from embolic phenomena. The latter has become a major consideration in all valve design. At present, up to 50% of all patients with prosthetic heart valves suffer emboli. The incidence has been lessened in recent years but is still significant. With homograft valves, emboli are nonexistent; anticoagulation is not required and, on this basis alone, long-term morbidity and mortality is reduced.

On the other hand, it is disturbing that an aortic diastolic murmur is present immediately following operation in from 7% to 38% of patients. The presence of this murmur does not necessarily indicate a poor result. On the contrary, many from this group become functionally Class I, with excellent hemodynamic function demonstrated by recatheterization.



Also, there is evidence that with increasing experience the percentage of initial diastolic murmurs significantly decreases.

However, there is also good evidence showing that the incidence of diastolic murmurs increases with time and, furthermore, that late valve failure does occur. Valve rupture has been reported in most series, but is most prevalent in valves obtained from older men and where beta propiolactone was used as a sterilizing agent. Histologically similar changes occur in the valves with gamma ray or beta propiolactone sterilization, but with gamma rays the changes are less marked and appear later.

Whether these changes are harbingers of later rupture must await the test of time. In this regard, fresh valves, sterilized by antibiotic solution, are being inserted in patients in a number of centers, but the operations are too recent to allow significant follow-up.

Homograft aortas were used by Gross 20 years ago to replace coarcted sequents of the thoracic aorta. With passage of time it became apparent that such grafts had a high frequency of calcification. Calcification also has been noted in homograft valves; in some cases as early as one year postoperative. As in the case of late valve rupture, there appears to be a correlation with technique of preservation. For example, Mcrindino's series had an incidence of nearly 10% valve calcification at four years, whereas calcification has occurred but once in 100 homografts sterilized by gamma ray emission reported by Gibbons and followed up to one year.

Autologous tissue also is being used to fashion artificial valves. Both fascia lata and pericardium are being used in free or fixed frame mitral and aortic prostheses. The advantage of using the patient's own tissue is obvious. The fascia lata or pericardium is not rejected as are homografts. Instead of a dead fibrous tissue frame into which the recipient's cells must grow, a viable tissue is supplied. Embolism incidence is very low and early reports are encouraging so far as functional ability of these tissues in the blood stream is concerned. The long-term durability must be determined. In vitro studies indicate great strength, but clinical trials are necessary to resolve this question.

At present the jury is still out. There are definite advantages and equally definite disadvantages to homograft use. The crux of the matter is whether the absence of morbidity and mortality from embolization is sufficient to offset the morbidity of late valve failure, the latter a problem of still unknown magnitude.

In our country an artificial valve, ready packed, easily sterilized, and rugged would be the prosthesis of choice if embolization could be eliminated. Presently accumulating data indicates that the recent modifications in valve design may have accomplished these aims.

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## Baltimore City health department

# Podiatry Clinic in Western Health District Building

A public podiatry clinic has opened in the Western Health District Building at 700 W. Lombard Street under the joint auspices of the Maryland Podiatry Association and the Baltimore City Health Department. The clinic offers treatment twice weekly: Tuesdays from 1:00 PM to 4:30 PM, and Thursdays from 9:00 AM to 1:00 PM.

Proposed and supported by the Maryland Podiatry Association, which has long recognized the need for such a clinic, the clinic is open to those on Medicaid or the Medical Assistance Program. It will be staffed by members of the Podiatry Association, public health nurses, and the clerical staff of the City Health Department.

The new foot-care treatment service represents a new departure for the City Health Department in its efforts to improve health services for the poor. This aspect of medical care, often neglected by peo-

ple of all ages, and not easily available or accessible to the poor in Baltimore city, should help improve the patient's well-being, aid his employability, and help reduce absenteeism.

According to Dr. I. I. Donick, who is associated with the Podiatry Association and is also co-director of the clinic, the achievement of foot health is far more important than the achievement of comfortable feet. Apart from the local discomfort of corns, calluses, bunions, or foot infections, neglected feet may be the cause of backache, cramps in leg muscles, unnecessary fatigue, and poor digestion. Self-treatment of ingrown toenails and calluses can lead to further trouble. Diabetics are especially urged to be alert to foot problems. Receiving early care can avoid major problems.

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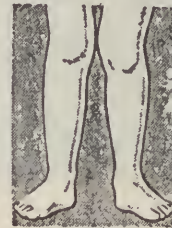
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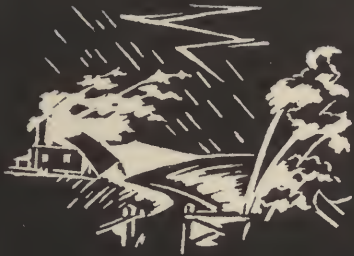


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## rehabilitation notes

# Patterns of Medical Care in a Municipal Hospital: Readmissions to an Acute Medical Service

Readmission to a hospital is often the result of progression or complications in the natural course of a disease. It may also be the result of inadequate instructions on the part of the physician, or misunderstanding, carelessness, or neglect on the part of the patient, the family, or the community. In any case, readmission to a hospital is very expensive to the patient and community, frustrating to the physician, and often has tragic results for the patient. This study was undertaken to see whether it was possible to identify any factors during a patient's first hospitalization which might allow recognition of a potentially high risk of readmission so that specific planning could be undertaken to prevent readmission.

### Materials and Methods

Between August 1, 1968 and December 4, 1968, 1,044 patients were admitted to the Acute Medical Service at the Baltimore City Hospitals. During this four-month period, 51 patients were discharged and readmitted once. Twelve patients were readmitted twice, two patients were readmitted three times, and one patient was readmitted four times. Transfers between services were excluded.

The records on all 66 patients who had one or more readmissions were then closely analyzed in retrospect. Our attention was particularly directed at the characteristics of the first admission, such as the urgency for the need of admission, the reason for admission, the duration of symptoms, medication administered while in the hospital, the patient's mental state on discharge, and follow-up expectations and arrangements.

Attention was next directed at what happened to the patient between his first discharge and first readmission in regard to his ambulatory status at time of discharge, the regularity with which he kept clinic appointments, the complaints on return, and the drug compliance as an outpatient.

A judgment was then made whether a failure on the part of the physician, the patient, the family,

or the community, or progression of the disease could be identified as an important factor in readmission. The apparent necessity for readmission was also evaluated. The final condition of the patient as of December 1969, one year after the period under study, was recorded.

It was found helpful to divide the patients into groups related to the nature of the underlying disease: those with diseases that were potentially curable, potentially fatal, or chronic, those readmitted for diseases different from the first admission, and those admitted for complications or unfinished study.

**GROUP I:** Patients with curable diseases, who had a normal life expectancy at time of discharge. There were no patients in this category.

**GROUP II:** Patients with neoplasms, who were expected to die from their neoplasm. Therapy might modify the course of the disease or prolong life, but the final expectation was death. There were 23 patients in this group.

**GROUP III:** Patients with a complication of an underlying chronic disease which in itself did not necessarily carry a high immediate mortality and expectation of early death. The underlying disease might or might not have been recognized prior to admission, but in itself did not call for hospital ad-



mission for treatment. Examples of such underlying diseases are coronary, cerebral or peripheral arteriosclerosis, and peptic ulcer disease. This group was divided into two subgroups:

**GROUP III A:** These patients had an underlying chronic disease, not in itself necessarily requiring hospitalization. The cause of the first admission was a physiological failure or event associated with the underlying chronic disease (acute heart failure, acute respiratory failure, acute delirium tremens, uremia, hepatic failure) which in itself did not result in permanent morphological change in tissues and was potentially reversible to the state prior to hospitalization (peptic ulcer, sickle-cell disease with pneumonia). There were 25 patients in this group.

**GROUP III B:** These patients had underlying chronic diseases, not in themselves necessarily requiring hospitalization. The cause of the first admission was progression or complication of the underlying disease which might be expected to lead to, or be a manifestation of, permanent morphological change in tissues despite treatment. Examples are acute myocardial infarction and cerebrovascular infarction. There were only two patients in this group.

**GROUP IV:** Included cases in which the cause of the first and second admission were unrelated. There were ten patients in this category.

**GROUP V:** Included those readmitted for complication or omission of first admission. There were six patients in this group.

## Results

Chart 1 shows the diagnoses in Group IIIA and B. These diagnoses were generally complications of underlying chronic diseases and make up the major proportion of those readmitted. Presumably, better care of many of these patients could have prevented their readmission.

**Chart 1: Diagnoses on patients with underlying chronic diseases (Group IIIA and B)**

GROUP IIIA	
Respiratory acidosis	5
Asthma	1
Cardiac failure	5
Angina pectoris	1
Alcoholism and complications	
Delirium tremens	2
Gastritis	1
Hepatic failure	1
Peripheral neuritis	1
Transient ischemic attacks	2
Uremia	3
Sickle-cell crisis	1
Porphyria	1
Fever of unexplained origin	1
<b>TOTAL</b>	<b>25</b>
GROUP IIIB	
Recurrent pulmonary emboli	1
Acute myocardial infarct	1
<b>TOTAL</b>	<b>2</b>

Chart 2 summarizes the important data on the different groups (see page 91).

There was little difference in mean age. There was a high incidence of multiple diseases. Very few patients were not on powerful drugs. Patients fulfilled return appointments well in Group II, very

poorly in Group IIIA. Few patients were without symptoms on return visits and a large number had to be readmitted at the first return visit. Drug compliance was poorest in Group IIIA.

The most frequent cause of readmission was progression of the disease.

## Discussion

Very few studies have been made of readmission to a general hospital. The present study shows that patients with neoplasms constitute a large part of this group. However, not a great deal can be done to prevent readmission. A second large group (IIIA) is made up of patients with chronic disease who are admitted because of a complication or exacerbation of the underlying disease. A great many of these patients suffer a physiological failure of one organ system or another and have the possibility of a complete reversal of the pathophysiological change, provided the condition is not too far advanced. This group was the largest of those readmitted. Patients in this group were taking a large number of potent drugs in a manner prescribed by their physician but, nevertheless, tended to remain symptomatic and have a recurrence of the organ system failure. It was impossible to delay admission in 14, but 11 patients could have been kept out of the hospital if certain community allied health personnel had been available. These resources were not available. However, even under these ideal conditions, it is unlikely that these patients could have been kept from being readmitted at a later period.

Readmissions seem to be brought about mainly by progression of underlying disease. This was not the only factor causing readmission. Thirteen patients did not return for any follow-up. Nineteen returned irregularly. The fact that 22 patients had to be readmitted on their first return visit suggests



that an earlier return visit might have resulted in a longer period in the home. Forty-eight patients complied well with drug directions as outpatients, six complied fairly well, seven poorly, and five did not

follow essential directions. Complications of treatment caused readmission in five patients.

These findings document less than ideal follow-up and use of the hospital.

**Chart 2: Age, number of diseases, in-hospital medications, regularity of follow-up, drug compliance, cause of re-admission and final results in patients readmitted to an acute medical service within four months.**

Group	II 23 51±19	IIIA 25 48±18	IIIB 2	IV 10 56±15	V 6 48±14
Number of Patients					
Age (mean, range)					
Number of Diseases					
1	16	17	1	5	4
2	6	7	0	3	2
3	1	1	1	2	0
Medications in Hospital					
1. Digitalis	2	9	0	4	3
2. Diuretics	2	8	0	5	2
3. Bronchodilator	0	5	0	1	0
4. Steroid	7	2	0	1	1
5. Antihypertensive	0	2	0	1	1
6. Antidiabetic	1	3	0	2	0
7. Antianxiety	3	2	0	1	1
8. Antibiotic	1	4	0	2	2
9. Anticoagulant	0	0	0	2	2
10. KC1	0	3	0	2	1
11. Analgesic other than aspirin	5	3	0	1	0
12. Antineoplastic	2	1	0	0	0
13. Endocrine	0	1	0	0	0
14. No drug	6	6	0	0	0
Regularity of Follow-up					
No return	1	9	0	3	0
Fulfilled appointments regularly	20	5	2	3	4
Fulfilled appointments irregularly	2	11	0	4	2
Status on Return Visit					
Asymptomatic and working	1	3	1	0	0
Asymptomatic and not working	4	4	1	1	2
Symptomatic	12	6	0	4	3
Disabled	1	0	0	0	0
Bedfast	1	0	0	0	0
Had to be admitted on first return visit	4	12	0	5	1
Drug Compliance as Outpatient					
Good	21	15	2	5	5
Fair	1	3	0	2	0
Poor	1	2	0	3	1
Did not follow directions	0	5	0	0	0
Cause of Readmission					
Doctor failure	0	0	0	0	0
Patient failure	1	3	0	1	0
Family failure	0	0	0	0	0
Community service failure	0	0	0	0	0
Progression of disease	18	10	2	6	1
Complication of treatment	2	0	0	0	3
Combination of above	2	12	0	3	0
Planned readmission	0	0	0	0	2
Final Result (one year after discharge)					
Died	17	6	0	0	1
At least one follow-up visit	2	4	2	4	1
Lost	4	15	0	6	4



We do not have information on other factors which may have been of great importance in preventing readmission. For example, we have assumed that if the physician included a plan for follow-up in his summary, he was fulfilling all the requirements for good follow-up care. We have no measure of whether the physician explained carefully to the patient the importance of return visits or the necessity of taking the medications. We do not know whether he established a relationship with the patient which encouraged return for a follow-up.

### Summary

In four months late in 1968, 6.3% of all admissions (66 patients) were readmitted to an acute medical service in a municipal hospital. Analysis of their age, diagnoses, number of diseases, regularity of follow-up, drug compliance, cause of remission, and final outcome was made.

It is concluded that about 55% of these patients were readmitted principally for progression of their disease. The remainder were readmitted because the patient had failed to carry out therapy as directed, because there was some complication of treatment, or a combination of more than one of these causes.

Furthermore, we have no way of being certain that the 37 patients who were thought to have been readmitted principally for progression of their disease could not have been treated better had they had more frequent return visits, better physician relationships, and better direction in use of medication.

This study suggests that patients with respiratory acidosis, asthma, cardiac failure and angina pectoris, and alcoholism and its complications constitute a group in which particular attention should be taken in regard to discharge and follow-up planning, if readmission is to be prevented.

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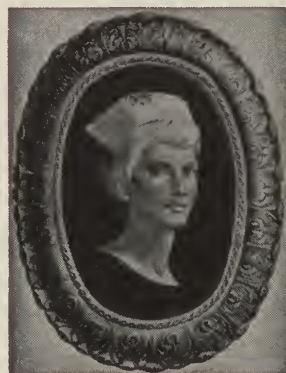
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## tuberculosis

# Treatment of Chronic Pulmonary Histoplasmosis

Amphotericin B was found to be the most effective therapy for reducing the number of relapses and deaths due to pulmonary histoplasmosis. A total dose of 35 mg/kg body weight was required to significantly reduce the case fatality ratio.

Four-hundred-eight untreated and treated patients with chronic pulmonary histoplasmosis have been followed for seven years. The purpose has been to determine how the untreated patients fared in contrast with patients who had undergone chemotherapy with amphotericin B, or surgery, or both.

Of the 408 sanatorium patients in this study, 238 were treated with amphotericin B alone (Group A); 100 were not treated (Group B); 43 were treated with chemotherapy and pulmonary surgery (Group C); and 27 were treated with surgery alone (Group D).

Diagnosis of histoplasmosis was verified by isolation of *Histoplasma capsulatum* from sputum or other specimens, or by examination of subcultures of the fungus. Some cases were verified by visualization of the fungus in tissue preparations.

The final decision on chemotherapy and surgery was left to the attending physician. In Group A, the total dosage of amphotericin B ranged from 250 to 5900 mg (3 to 108 mg/kg body weight).

After a patient was discharged, an attempt was made to obtain follow-up information on the pro-

gression or regression of disease at six-month intervals for a year, and at yearly intervals thereafter. Death certificates or autopsy reports, or both, were obtained on all patients who died.

In this study, relapse was defined as the reappearance of *H. capsulatum* in sputum cultures, or a worsening of the chest film and symptoms after termination of therapy without other apparent cause. Treatment failure was defined as the persistence of the organism in cultures throughout and after therapy. In Group A, there were three such treatment failures of whom two died of respiratory insufficiency 20 to 74 months after the start of therapy. The third was alive at the end of 120 months of follow-up, although his chest film showed worsening of his disease.

### Mortality and Morbidity

At the end of the fifth year after initiation of chemotherapy, 28% of the patients in Group A had died; 15% had relapsed. By comparison, 50% of the untreated patients in Group B had died five years after diagnosis; another 18% had regressed.

In Groups A and B, death was directly related to the age of the patient at the time of diagnosis.

Mortality was inversely related to the dose of amphotericin B in Group A ( $p$  equal to 0.05). Sig-

J. D. Parker, MD; G. A. Sarosi, MD; I. L. Doto, MA; R. E. Bailey, MS; and F. E. Tosh, MD. The New England Journal of Medicine, July 30, 1970 (Vol. 283, No. 5).



nificantly more patients receiving a total dose of less than 35 mg/kg of body weight of amphotericin B died (39%) than those receiving more than 35 mg/kg (26%) ( $p$  [chi square] less than 0.05). There were no deaths in Group A before therapy was completed.

Relapse in Group A and surgical Groups C and D was inversely related to duration of follow-up, with most relapses occurring early in the follow-up period. In the surgical Groups C and D, neither drugs nor the amount of lung removed appeared to have any bearing on the death or relapse rates. Surgical patients had a significantly higher incidence of unilateral disease.

Seven of the 25 relapsed patients treated with amphotericin B or surgery, or both, died. Eight of the 25 relapsed patients not treated or treated with investigational drugs died.

#### Chemotherapy vs Surgery

Although an occasional patient has what appears to be a self-limiting form of the disease which regresses with bed rest, most are afflicted with a more severe progressive disease. At least this was true of the sanatorium population in this study.

Taking into account the grim prognosis of untreated, severe, progressive histoplasmosis, as unfolded in this and other studies, it seems wise to treat all chronic pulmonary histoplasmosis patients with amphotericin B.

Regarding dosage, this study indicates that a total dose of 35 mg/kg of body weight is required to significantly decrease the fatality ratio.

The role of surgery in the treatment of chronic pulmonary histoplasmosis is uncertain. It is often necessary for diagnosis and certainly has a place in the treatment of the right middle-lobe syndrome and symptomatic bronchiectasis due to histoplasmosis.

The controversy over surgery concerns its use in the treatment of residual cavitation. A recent article stated that indications for surgery in chronic pulmonary histoplasmosis are the same as for cavitary tuberculosis—that is, persistent cavitation over 4 cm in diameter or persistent cavitation without improvement.

Data in the present study show that surgical therapy is no more effective than chemotherapy alone in reducing the number of relapses and deaths. Indeed, when the age of the patient and the extent of his disease was taken into account, it proved to be no more effective than bed rest in reducing mortality.

Furthermore, in the study group, cavitation was not found to be related to relapse or to death. Too strong a stand on this issue cannot be taken, however, because of the small size of the surgical groups, and also because cavitation was determined by PA chest film only. A prospective randomized study using tomograms might resolve the issue.

The possibility of postoperative complications must be taken into consideration in surgical therapy. In the present study, 15 surgically treated patients (21%) had postoperative complications.

#### Pre- and Postoperative Therapy

Although preoperative amphotericin B has been advocated to prevent complications, data from this study do not support the recommendation—possibly because of the small number of cases analyzed. However, the strong inverse relationship between the drug and the relapse or death ratio suggests that amphotericin B should be administered when pulmonary surgery is performed.

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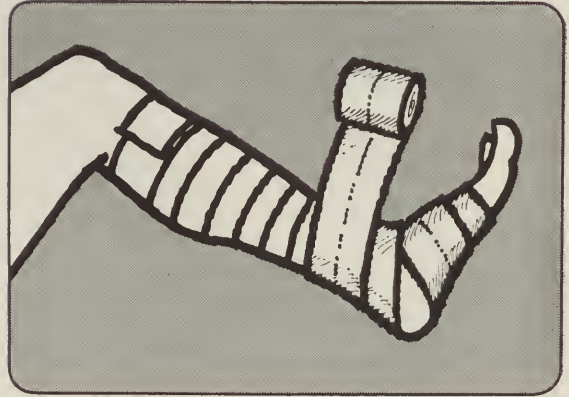
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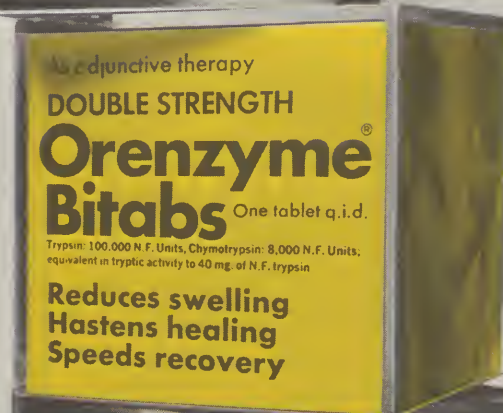
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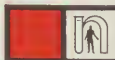
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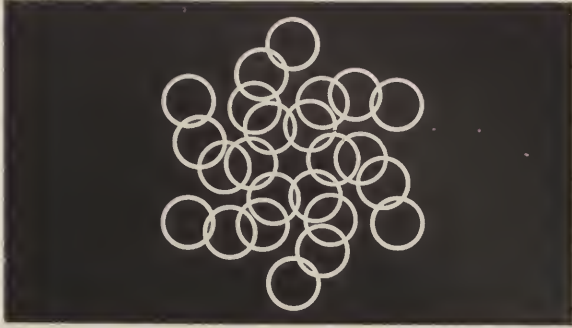


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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# Incidents of Alcohol and Drug Related Arrests

**E. PAUL HOOVER**  
Alcoholism Coordinator  
Carroll County Health Department  
Westminster, Maryland

In the past few years, communities all across the nation have been emphasizing the need for the immediate establishment of programs to combat drug abuse. The basis for the establishment of such programs is the relationship of drug abuse to crime and the immense cost to society in terms of these crimes. This problem has resulted in political hearings and legislative packages attempting to alter existing laws and establish drug treatment programs.

The National Council on Alcoholism reports that in 1968 the federal government appropriated \$4 million for alcoholism programs to meet the needs of an estimated 6,500,000 alcoholics. That same year, the government spent \$21 million for research and treatment programs for an estimated 64,011 narcotic addicts throughout the nation.

The Maryland State Department of Mental Hygiene, through its Division of Alcoholism Control, made it possible for the Alcoholism Division of the Carroll County Health Department to do a six-month preliminary study to determine comparative costs of drug and alcohol abuse in terms of criminal actions.

In this report, an attempt was made to review all arrests in Carroll County from January 1, 1970 through June 30, 1970 and to determine how many of these arrests were alcohol-related and how many were related to the use of drugs. These incidents were divided into arrests for crimes against property and arrests for crimes against people, with an attempt to give some indication of the cost of damage done and the disposition of the individual arrested.

Carroll County is considered a rural county comprised of one central population center of approximately 16,000 people and eight smaller centers with about 2,000 residents in each, coupled with the rural residents, for a total population of 68,000

(1970 census). The county is not industrialized. Most businesses are small and locally owned, employing no more than several hundred persons.

The state and the city police records of eight cities in Carroll County were reviewed for the six-month period. One city does not have a police department and is served exclusively by the state police system. The county had no police force and the duties of the sheriff do not extend into this area.

The records of the state police and Westminster city police were written and documented, and were reviewed personally by the author. The statistics gathered from the remaining seven law enforcement agencies were given verbally to the author by the



respective chiefs of police as they reviewed their own record system.

It should be noted that the law enforcement agencies were not gathering information for the accomplishment of this report, and this retrospective study had no effect on the objectivity of the officer. This makes the survey somewhat conservative in its final results. For example, there were 166 complaints of malicious destruction of property resulting in 14 arrests, 134 disorderly conduct reports made resulting in 35 arrests, and 77 assaults during this six-month period. Very few of these investigations included any mention of alcohol, but a review of the records would lead one to believe that more of these offenses were related to alcohol. There were no charges of disorderly intoxication during this period. The same conservatism was present among 103 reported thefts resulting in 11 arrests, with no reported evidence sufficient to relate these or any of the assault and battery charges to abuse of drugs. For those who attempt to interpret the report and for those who review the information presented, these factors are important.

The reviewer must also remember that the purpose of this survey was to relate alcohol and drug abuse to crime, and not specifically alcoholics and drug addicts to crime. It is impossible within our present recording system to substantially differentiate between simple intoxication resulting in a violation, and the addict who is intoxicated and commits the violation. It should be noted, however, that since both the addicted intoxicant and the social intoxicant are integrated in this report, both groups are involved in crimes against property as well as crimes against persons and, therefore, both groups should be addressed by those interested in solving the problem.

The following chart indicates the tremendous numerical difference between arrests related to alcohol abuse and arrests related to drug abuse. "Crimes against persons" are defined as those incidents involving physical injury where alcohol or drugs were a related factor. "Crimes against property" included those incidents resulting in some property damage other than personal injury, where alcohol or drugs were considered to be a causative factor. The summation of these two categories left uncounted those

incidents in which no harm resulted. Crimes without victims are designated as "Crimes of possession".

	Number of Arrests	Crimes Against Persons	Crimes Against Property	Crimes of Possession
Drugs	4	None	None	4
Alcohol	129	58	68	12

All drug arrests were listed as "Crimes of possession" involving only the arrested individual and resulting in no further violation. Each of the four people was less than 18 years of age.

In the 129 alcohol-related incidents, the violations were divided among all three categories. Traffic violations played a significant role, accounting for 77 of the 129 incidents.

Among the "Crimes against persons" are ten reported incidents of physical harm to others, inflicted directly by the arrested individual. The remaining 48 are persons injured in traffic accidents who required medical treatment of some nature. One of these injuries resulted in death to the injured. The cost of these incidents is felt by society in the form of deaths, disabilities, loss of work time, and increased insurance premiums.

All 68 alcohol-related "Crimes against property" were the result of traffic accidents. The total property damage for the six months was estimated by the police to be more than \$40,000, a cost borne by society through increased insurance premiums.

The 12 alcohol-related "Crimes of possession" were committed by persons under 30 years of age. The majority were "under 21" offenses, while several were charges of obtaining an alcoholic beverage for a minor. In 77 of the 448 traffic accidents (or 15% of all the traffic accidents in the county) alcohol was a notable "existing factor".

One of the nine traffic fatalities was included in this category. Since several individuals sustained more than one violation, it is obvious that the number of people involved in alcohol-related offenses totals more than 129.

There were several other significant observations in age, sex, and racial distribution of these offenses, although no comparative conclusions can be drawn because of the small number of drug offenses.

Age Distribution In Ten-Year Cohorts

	Under 19	20-29	30-39	40-49	50-59	60-69	70 and over
Drugs	4	0	0	0	0	0	0
Alcohol	25	44	30	12	8	8	2

As shown in the chart above, the four people accused of drug abuse were less than 19 years of age, while the use of alcohol is distributed through all the age cohorts. Drugs appear to be socially acceptable only within the youth culture. More than

50% of the alcohol offenders were less than 30 years of age.

Three of the four drug offenders (or 75%) were men, while 88% of the alcohol offenders were men. The survey indicated that the four drug offenders



were white and 95% of alcohol offenders were white. The latter reflects the racial composition of the county.

It appears from this study that alcohol-related offenses in Carroll County cost residents their lives, caused disabling injuries, and resulted in loss of work time, more than \$40,000 in property damage, increased insurance premiums, and untold thousands of dollars in medical services (plus pain and suffering), while the cost of drug-related offenses was almost negligible for the six-month period.

From this report, it appears that alcohol costs society far more than drugs in terms of crimes against persons and property. It will be important for parents, public-spirited citizens, local leaders, and state legislators to keep alcohol and drug abuse in their appropriate perspective as they plan for the needs of Carroll County. Since alcohol is a socially acceptable and legal beverage, it is difficult for the community to place its abuse in the correct perspective without endorsing prohibition. Such a change in perspective involves the development of a comprehensive community educational program involving schools, highway safety, industry, the courts, law enforcers, and professionals within the county. Rather than neglect either problem, it is urged that citizens realign their goals in keeping with the evidence presented above.

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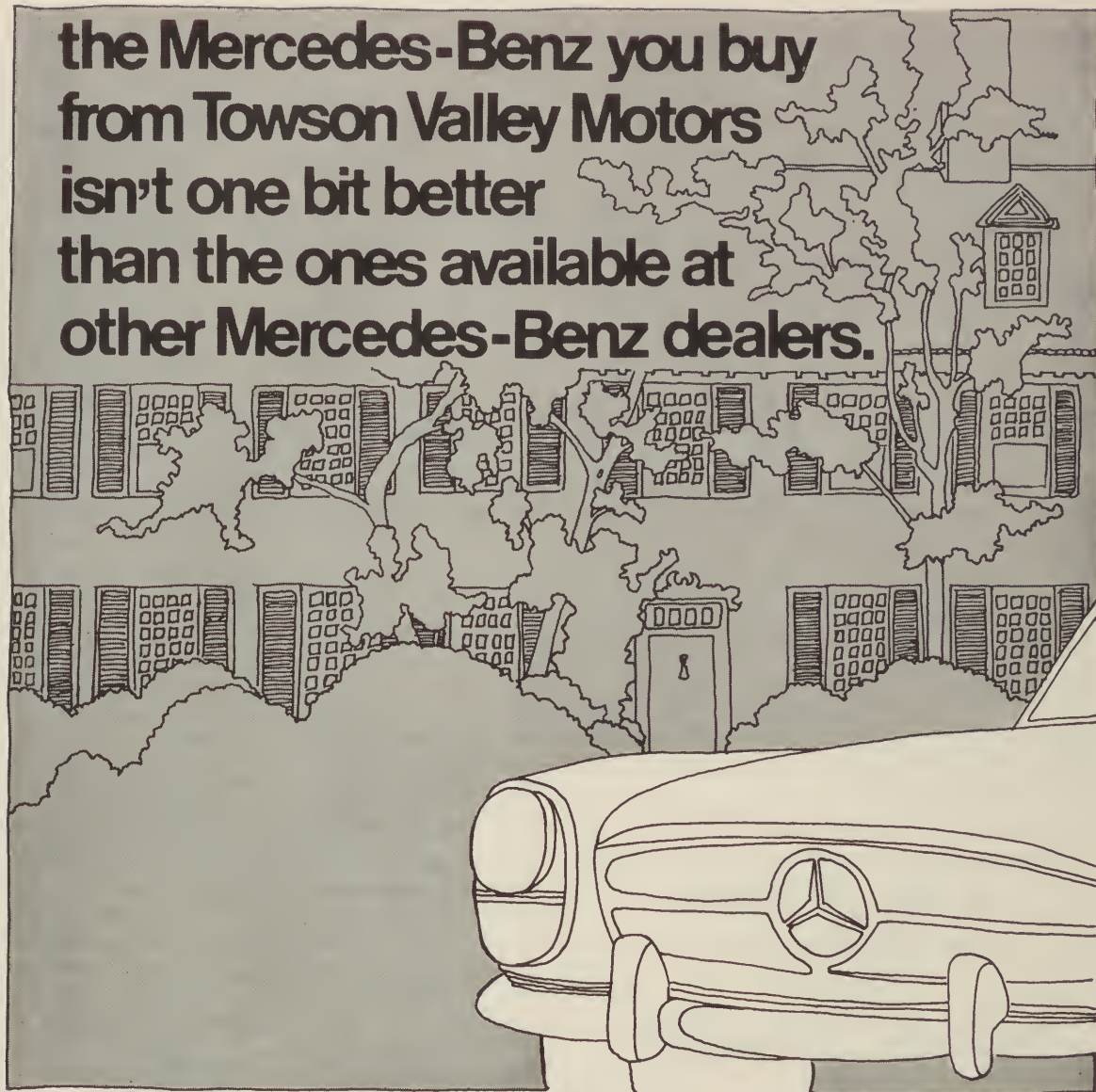
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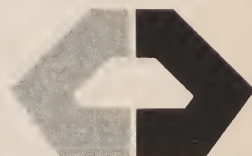
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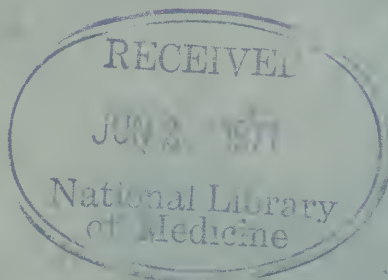
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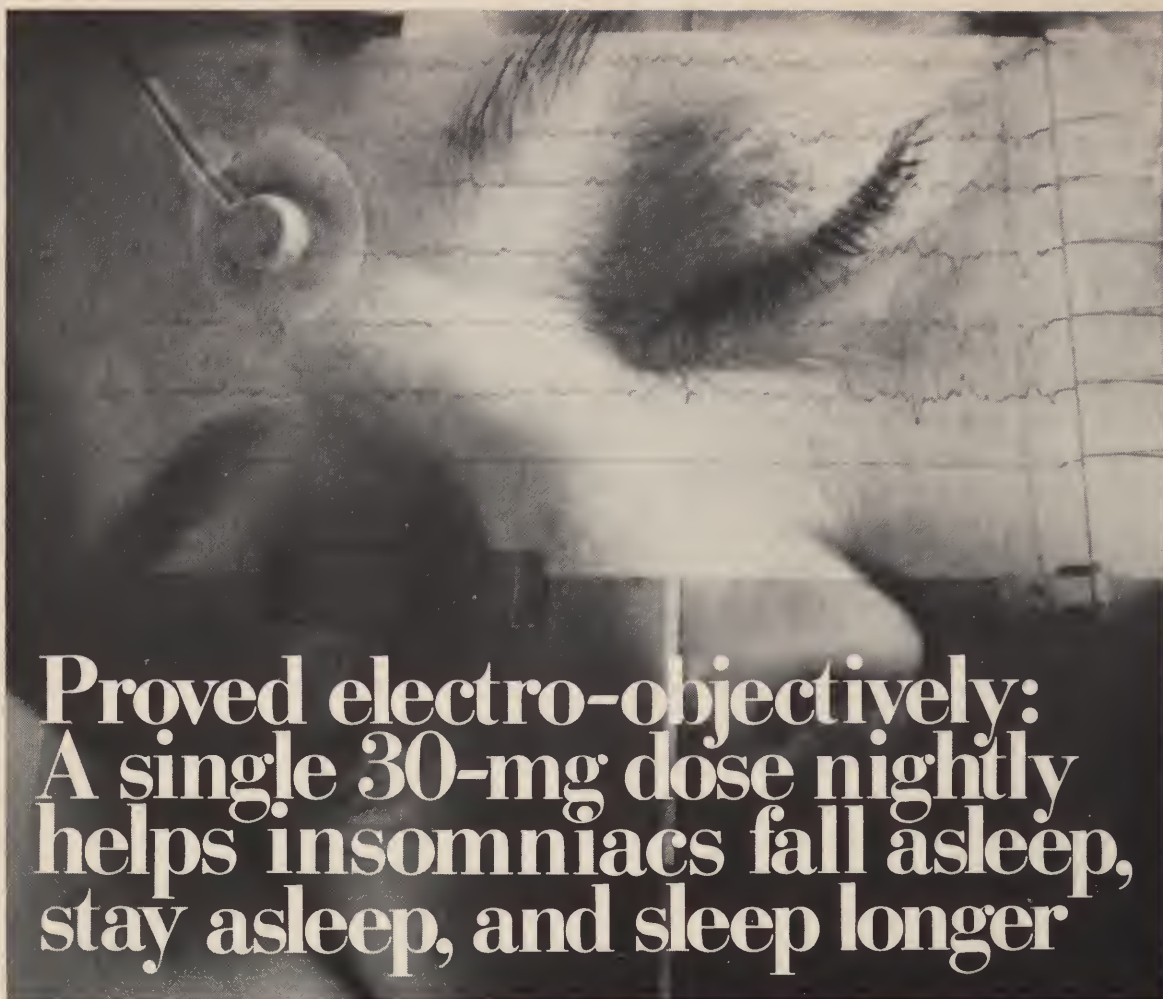


MAY 1971

READING  
ROOM







# Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.<sup>1,2,3</sup>

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,<sup>1</sup> Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

---

## Confirmed clinically

---

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.



In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

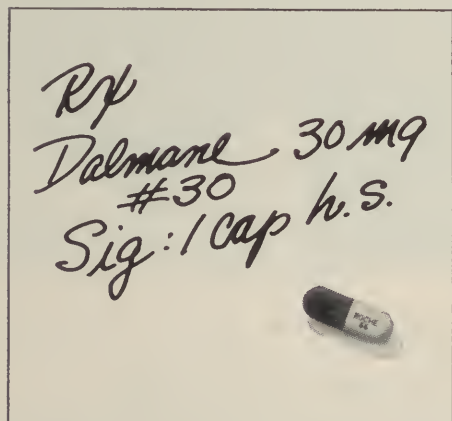
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### Dalmane (flurazepam HCl) is generally well tolerated

---

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.<sup>3</sup> Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

**References:** 1. Kales, A., *et al.*: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in *Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol.*, San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., *et al.*: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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### Before prescribing, please consult Complete Product Information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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# maryland state MEDICAL JOURNAL

VOLUME 20

MAY 1971

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# Doctors take note...

**MAY 17-19, 1971**  
**AMERICAN CANCER SOCIETY**

2nd National Conference on Breast Cancer: Century Plaza Hotel, Los Angeles, California. Contact: Esther Kelley, Professional Education, American Cancer Society, Inc., 219 East 42nd St., New York, N.Y. 10017.

**MAY 18-21, 1971**  
**AMERICAN PUBLIC HEALTH ASSOCIATION, SOUTHERN BRANCH/TENNESSEE PUBLIC HEALTH ASSOCIATION**

Joint Meeting—Universal Health Care: A Challenge to Public Health: Sheraton Peabody Hotel, Memphis, Tennessee. Contact: Mrs. Mildred Hicks, Information Supervisor, Memphis-Shelby County Health Department, 814 Jefferson Ave., Memphis, Tennessee 38105.

**MAY 19-21, 1971**  
**UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE**

Short Course—Topics in Internal Medicine: University of Florida, Gainesville, Florida. Contact: Mark V. Barrow, MD, Division of Cardiology, Department of Medicine, College of Medicine, University of Florida, Gainesville, Florida 32601.

**MAY 19-21, 1971**  
**AMERICAN COLLEGE OF PHYSICIANS/COUNCIL OF CLINICAL CARDIOLOGY, AMERICAN HEART ASSOCIATION, INC.**

Postgraduate Course—Clinical Auscultation of the Heart: Georgetown University Medical Center, Gorman Building Auditorium, 3800 Reservoir Road, NW, Washington, D.C. For further information, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

**MAY 19-22, 1971**  
**AMERICAN COLLEGE OF PHYSICIANS/CONTINUING MEDICAL EDUCATION, SCHOOL OF MEDICINE, STATE UNIVERSITY OF NEW YORK AT BUFFALO**

Postgraduate Course—Immunologic Concepts of Hypersensitivity in Man: Statler Hilton, Buffalo, New York. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

**MAY 20-21, 1971**  
**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Medical Genetics: Seattle, Washington. Contact: University of Washington School of Medicine, Health Science Building, Seattle, Washington 98105.



**MAY 21-23, 1971**

**AMERICAN ACADEMY OF FAMILY PRACTICE**

Annual Meeting: Host Corral, Lancaster, Pennsylvania. Contact: Mrs. Dorothy E. Holman, Executive Secretary, 8523 Loch Raven Boulevard, Baltimore, Md. 21204.

**MAY 24-26, 1971**

**AMERICAN HEART ASSOCIATION**

Scientific Sessions of the Wisconsin Heart Association—An Appraisal of Coronary Surgery 1971; Milwaukee, Wisconsin. Write: Heart Association of Maryland, 415 N. Charles St., Baltimore, Maryland 21201.

**MAY 24-28, 1971**

**AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Clinical Endocrinology: Physiological Basis for Current Diagnostic and Therapeutic Procedures: Towsley Center for Continuing Medical Education, The University of Michigan Medical Center, Ann Arbor, Michigan. Director: J. W. Conn, MD; Co-director: Stefan S. Fajans, MD, FACP. Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104.

**JUNE 1-4, 1971**

**AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Selected Topics on the Pathophysiology of Clinical Gastroenterology: University of California, San Francisco Medical Center, Medical Sciences Auditorium, 3rd and Parnassus Aves., San Francisco, California. Director: Marvin H. Sleisenger, MD, FACP. Credit of 26 hours allowed toward AMA "Physicians' Recognition Award." Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104.

**JUNE 3, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Birth Control and Population Growth: Plymouth, Indiana. Contact: Marshall County Medical Society, 109 North Walnut Street, Plymouth, Indiana 46563.

**JUNE 3-4, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Gynecologic Endoscopy: Livingston, New Jersey. Contact: James L. Breen, MD, Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, New Jersey 07039.

**JUNE 4-6, 1971**

**TIDEWATER HEART ASSOCIATION AND COUNCIL ON CLINICAL CARDIOLOGY, AMERICAN HEART ASSOCIATION**

11th Annual Cardiovascular Symposium: Cavalier Hotel, Virginia Beach, Va. Contact: A. A. Douglas Moore, MD, Chairman, Professional Education Committee, 523 Boush Street, Norfolk, Va. 23510.

*(Continued on page 48)*



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# executive director's newsletter

May, 1971

## NEWLY ENACTED LEGISLATION

Be on the lookout for the roundup issue of The Assemblyman, which will give the status of all bills introduced, considered, and enacted by the 1971 General Assembly.

Important new legislation, effective July 1, 1971, will provide for:

1. Treating an individual without parental consent (a) if he is 18 years of age or over; (b) if he is the parent of a child; (c) for venereal disease or pregnancy, or suspected pregnancy; (d) for contraceptive information, other than sterilization; and (e) for drug abuse.
2. Including the name and strength of the medication on all prescription labels, unless the physician indicates otherwise.
3. Lowering the age from 18 to 16 when a minor may obtain treatment for emotional illness without parental consent.
4. Including as a cause for disciplinary action against a physician's license the physician's failure to disclose on his bill the amount paid to a laboratory for laboratory services, and his fee for taking and preparing the sample. (This is in accord with current ethical policies adopted by the Faculty.)
5. Excluding from liability any physician, hospital, donor, or others involved in blood transfusions if virus hepatitis is caused by blood containing such virus.

For additional details or information on any of the above items, contact the Faculty office.

## NEW DRUG REGULATIONS

Physicians throughout the country are currently being reregistered by the U.S. Bureau of Narcotics and Dangerous Drugs under the new federal drug legislation adopted by Congress last year.

Physicians are reminded that when their current supply of Rx blanks is used up, to be sure to use their newly assigned federal narcotics number.



VACCINATION  
STAMPS

Members are also reminded that vaccination forms may be mailed to their local health department or the State Health Department for the verification stamp of the physician's signature. Any physician giving a large number of vaccinations annually may be issued a personal verification stamp, on request to the State Department of Health.

PROFESSIONAL  
LIABILITY  
PREMIUMS

While Maryland ranks 20th lowest nationally in its premiums for professional liability insurance, this standing may change when present proposals before the state insurance commissioner are acted on.

Rates will be increased as follows:

All rates based on \$100,000/\$300,000  
policy limits

<u>Class</u>	<u>Present Rates</u>	<u>Proposed Rates</u>
1	\$163	\$ 245
2	287	431
3	490	930
4	653	1,240
5	816	1 550

This data was presented to the Medical Economics Committee on Wednesday, April 14, 1971, and to the state insurance commissioner the following day.

The St. Paul Companies, which writes this category of insurance in about nine states throughout the country, is revising its rate structures in all states. Comparative increases are being requested in other states.

UNIT VALUE  
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To those members of the Med-Chi retirement plan who made contributions in February 1971, the unit value of the fund was \$1.32.

  
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# Professional Ideals: A Report of the Judicial Council Adopted by the House of Delegates, December 1, 1970

Recently, many letters have been received by the Judicial Council complaining of an apparent preoccupation by an increasing number of physicians with the financial aspects of their medical practice.

The Judicial Council reaffirms that the laborer is worthy of his hire and the physician is entitled to reasonable compensation for the service he performs. At the same time, the council must point out that the "prime object of the medical profession is to serve humanity; reward or financial gain is a subordinate consideration."

In 1934, the House of Delegates said, "one of the strongest holds of the profession on public approbation and support has been the age old professional ideal of medical service to all, whether able to pay or not." The Council believes it would be helpful if the house were to reaffirm that policy at this meeting.

Some physicians seem to believe that the practices of business enterprises should be utilized by physicians in order to "encourage prompt attention to medical accounts." They ask, "Why shouldn't we be paid as soon as the dry goods store, the grocer, or the TV service man?"

Ideally, the physician should be paid promptly. If the physician is not paid as promptly as other creditors, he should recall that he is a professional man with all the perquisites that that term implies. Our patients in large number carry insurance to cover the cost of medical services. (They do not insure payment of the cost of other professional or business services to any notable extent.) Governmental programs have been instituted and are being developed continually to provide payment for medical care to those who are unable to provide this payment.

If the profession were to cast aside its ideals and traditions and adopt the practices of business, trade, or industry in dealing with patients, then the profes-

sion would also be casting aside the perquisites that have been accorded it. The increase of collections by adding 1½% interest a month to a bill of an honest patient embarrassed because of inflationary trends, or the bill of some retired person living on a small pension is, in the opinion of the Judicial Council, not justifiable. It simply is not worth it from any point of view. The imposition of a penalty on the bill of a "deadbeat" is not likely to cause him suddenly to change; the chances are he will become even less likely to pay.

A physician who demands a satisfactory credit report on an individual before accepting that individual as a patient is demonstrating that to him financial compensation is the prime object and reward of his profession.

A physician who publicly refuses to see a patient who had an appointment, because that patient's balance on account was "too high", is demonstrating that he respects neither himself nor his profession.

These examples are real. The Council believes they are the exception and they seem more conspicuous because of that fact. Nonetheless, these practices adversely reflect on the whole profession and especially on the countless physicians who extend credit willingly or write off old accounts because they are dedicated to serving mankind.

The Judicial Council therefore recommends that the House of Delegates reaffirm that the prime object of the medical profession is to render service to humanity; financial gain is a subordinate consideration.

The Council recommends that the House call this reaffirmation of policy to the attention of constituent and component medical societies, asking them to urge all physicians to adhere faithfully to the professional ideals, traditions, and goals of American medicine.

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## Most Accidents Happen At Home

There's no place like home for having an accident. It is, according to the Health Insurance Institute, the most likely spot for an injury to occur.

In 1970, according to an analysis of data from the National Center for Health Statistics, about one out of every four persons in the United States was injured—the largest proportion at home.

The data shows that about two out of every five accidents occurred at home.

At the same time, 1 in 14 accidents will involve motor vehicles, with more than 3.4 million persons being injured.

Overall, about 50 million persons will be injured; more than 20.4 million at home, about 9.3 million at work, and about 17.4 million through a variety of other causes.

### Lose 553 Million Days

Because of these accidents, government sources estimate that more than 553 million days of restricted activity will occur, more than 283 restricted days for each 100 persons in the nation.

There will also be an estimated 139 million days of bed disability due to the injuries during the year, or about 71 days of bed disability for each 100 persons.

Of the bed disability days, home injuries will cause about 45 million, moving motor vehicle accidents about 27 million, and work accidents 31 million.

The majority of accidents will effect men—an estimated 30 million—while women will be in about 20 million of them.

The age group suffering the largest percentage of accidents will be those between 6 and 16 years, while children under six years of age are the next most accident-prone group.

The number of persons injured per 100 persons decreases from age groups 17 to 44, 45 to 64, and reaches the lowest level in persons 65 years and over.

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# Baltimore County Medical Association

The regular monthly meeting of the Baltimore County Medical Association was held on February 17, 1971 at the Greater Baltimore Medical Center. Following a delicious luncheon provided by the hospital, the meeting was called to order by the president, John Krager, MD.

Dr. Krager welcomed the members and introduced three new members: Dr. Maffezzoli, Dr. Pushkin, and Dr. Ferris.

Dr. Hopf announced that a repeat rubella immunization campaign would be held on April 25, 1971 in Baltimore County. This campaign was designed for those children up to the age of 12 years who were missed by the previous program. Physicians were asked to volunteer their services.

The following applications for active membership were approved: Krikor Boyagian, MD, Robert Brandt, MD, John Carroll, MD, Gerald Glowacki, MD, Antonia Grandea, MD, Ku Sung Hsu, MD, Marius P. Johnson, MD, Massoud Kaye, MD, Robert McFadden, MD, Fidel Montes, MD, Rogelio Naraval, MD, Lutgardo Panlilio, MD, Harry Randell, MD, William Reichel, MD, Stanley Rosendorf, MD, Peter Ruy, MD, and Warren Wurzbacher, MD. The application of Mohammad Inayatullah, MD, for affiliate membership was approved, as well as that of Robert Kent, MD, for associate membership.

Dr. Krager thanked the staff of the Greater Baltimore Medical Center for inviting the association to have its meeting there.

There being no further business, the meeting was adjourned.

Following the meeting, an excellent scientific program was presented by the staff of the Greater Baltimore Medical Center.

Alfred E. Iwantsch, MD  
Chairman, Public Relations Committee

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hydrochlorothiazide

0.1 mg  
25 mg  
15 mg

**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hyponatremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxic anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine:** Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

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# C I B A





ARTHUR E. COCCO, MD  
Journal Representative

## **Baltimore City Medical Society**

# **Board of Directors Meets**

The March 9 meeting of the Board of Directors was called to order by the President, Philip F. Wagley, MD, at 4:30 P.M. The minutes of the February 9 meeting were approved as distributed and the board turned its attention to a discussion of the Comprehensive Health Planning Agency of the Regional Planning Council.

Mr. William Mc. Hiscock, Director, Comprehensive Health Planning, outlined the makeup of the Regional Planning Council, and its duties and objectives. There is a very complex structure of responsibilities in the various areas covered by the council. There are several panels representing broad interest groups which elect delegates to the Planning Council. The Baltimore City Medical Society is represented on the Professional Associations and Licensing Bodies panel by Harry F. Klinefelter, MD.

The Comprehensive Health Planning Agency has broad powers in establishing policies in the health field. The agency must approve not only any new hospital construction, but any addition to existing facilities regardless of the size or type of that addition. Mr. Hiscock was informed of the society's interest in this agency and was urged to contact the board at any time for assistance.

Bernard Karpers, MD, the society's representative on the Cherry Hill Task Force Committee, had submitted a request that the society consider making a donation to this group to support its objective of establishing a comprehensive health-care center. Since expected federal funding was halted, the group must look for another source of financial support. After some discussion, it was decided not to acquiesce to this request at present, as a contribution from

the society would do no more than show good will. The sum needed is very large and some means of government support will be necessary before definitive plans can be made.

The board denied acceptance of an application which had been falsified, and referred the problem to the Faculty's Mediation Committee.

Approval was given for Joseph S. McLaughlin, MD, to list both cardiovascular and thoracic surgery as specialties in the telephone directory.

It was agreed to purchase an alphabetical listing of physicians in Baltimore city from the health department. This will be used in the society office to determine the number of physicians in the city who belong to the society.

After minor wording changes, the board agreed to submit the resolution regarding the home-care services program to the Medical and Chirurgical Faculty House of Delegates at the Annual Meeting. This resolution was adopted by the City Society at its meeting on January 7, 1971.

A resolution from the Medical Care Committee, which had been presented at the March 4 meeting of the society concerning the delivery of medical care, was approved after several wording changes.

Another resolution presented at the March 4 meeting concerning the publication of physicians' names and the amounts received under Title XIX was also approved by the board after wording changes. Both of these resolutions will be acted on at the society's April meeting.

Worth B. Daniels, MD, chairman of the Legislative Committee, then gave the board a brief resumé of the bills presently under consideration by the



Maryland legislature. Of the numerous bills concerning health which have been introduced in the state legislature, Dr. Daniels felt that the society should be most concerned with three in particular. The liberalization of abortion is supported by Med-Chi and, at the time of this report, it was not known what the final outcome on this bill would be. There is also a bill which would place the Drug Abuse Authority under the direct control and responsibility of the Secretary of Health and Mental Hygiene. The Drug Abuse Authority has been ineffectual since its inception because it has concerned itself more with the idea of whom it should report its findings to, rather than formulating and coordinating plans for prevention and treatment of drug addiction. It is hoped that this bill will correct the situation and the authority will be clearly defined.

Two other bills have been introduced which deal with the use of paramedical personnel. H.B. 569 introduced by Dr. Torrey Brown calls for certification of paramedical personnel and would give wide latitude as to whom would be considered for certification. In opposition to this, Med-Chi requested that Dr. Aris Allen introduce H.B. 735. This bill allows for the licensing of paramedical personnel

giving definite educational guidelines which must be followed. It was the consensus that neither of these bills should be enacted at this time, as this is a very new concept and needs much study before legislation is provided. There is certainly a tremendous need for paramedical personnel, but it would not be wise to enact legislation which would reduce educational requirements to a point where quality would be sacrificed.

Dr. Daniels also reported that he felt the society was not and could not be a potent force in the legislative community except as a part of Med-Chi or in the City Council. He stated that Mr. Sargeant spends most of his time in Annapolis during the legislative session and is still hard put to keep track of every bill that is proposed. He felt that there was little action on the part of the City Council in the area of medical legislation, but that this might be due to lack of pressure from the City Society.

Dr. Daniels also suggested that possibly the society should institute a regular meeting with members of the legislature to encourage freer exchange of ideas and information.

There being no further business, the meeting was adjourned at 6:30 PM.

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**WARNING:** Do not give in advanced kidney or liver disease.

**PRECAUTIONS:** Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. **DOSAGE:** 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

**NOTE:** The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.

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**HANDBOOK OF PEDIATRICS**, Henry K. Silver, MD, C. Henry Kempe, MD, and Henry B. Bruyn, MD; Lange Medical Publications, Los Altos, California, 1971.

The ninth edition of this handbook contains extensive revisions and additions; but the format and objectives have remained the same: to present the practicing physician and medical student with a concise and readily available digest of material necessary for the diagnosis and management of pediatrics.

This handbook is not intended to be used as a substitute for the more complete pediatric texts and reference works, but only as a supplement. It certainly accomplishes this well.

**AN INTRODUCTION TO NEUROSURGERY**, W. Bryan Jennett, MD; The W. B. Saunders Company, Philadelphia, Pennsylvania, 1970.

This is the second edition of this publication. Since the first edition was published six years ago, there have been significant technical developments affecting methods of investigation and treatment. Most changes in the text of this edition cover these new developments.

This book provides a framework within which more detailed and up-to-date information can be accommodated. Several tables have also been introduced as well as over 20 new illustrations.

It is an excellent reference book and one that is well worth adding to your medical library.

**THE SHEPPARD AND ENOCH PRATT HOSPITAL, 1853-1970; A HISTORY**, Bliss Forbush, LLD; J. B. Lippincott Company, Philadelphia, Pennsylvania, 1971.

This publication has a most illuminating foreword

by Lawrence S. Kubie, MD, ScD. Dr. Kubie emphasizes the original philosophies of the hospital, tracing them through the evolutionary process that has taken place over the years. He is ever mindful that the "... Hospital is a sample of all human life; a microcosm that has passed through the changes through which all human culture has passed in this century. All of this appears in the story of the ... Hospital ..."

While Dr. Kubie's foreword is illuminating, the book itself is more so. It traces the growth of the hospital from the time that Moses Sheppard died and left his estate for the hospital's founding, through the latter years of the hospital's existence.

More interesting highlights include the fact that in 1892, the institution was threatened with legal action in connection with a woman who committed suicide; that the hospital's trustees devoted their efforts for nearly 30 years to acquiring land and buildings before admitting the first patient in 1891; that in 1912, the hospital sold two acres of land at \$300 an acre to the Towson Normal School; and that the Nurses Training School started in the early years of the institution was perhaps one of the first for psychiatric nursing in the country.

But these are only some of the interesting highlights. During the depression of the thirties, the institution pared expenses by cutting off the electricity to the elevators in the reception building, using smaller wattage light bulbs, and hiring a deaf and dumb man as a painter, so he would not spend so much time in conversation.

During World War II, during a staff shortage, the hospital turned to using patients to perform those chores that they were capable of. This system resulted in a remarkable improvement in some patients, who were now gainfully employed doing something in which they could see results. This was the start of the work program at Sheppard.

The introduction of chemotherapy changed treatment concepts at Sheppard, and these concepts were quickly taken advantage of. During the 1950's, the institution concentrated on improving its teaching ability, which it did remarkably well.

During the 1960's, the hospital worked on improving the physical plant and continually upgrading the scientific quality of the teaching and treatment programs. It was during this period that large blocks of land no longer needed by the hospital were sold to outside institutions.

In summary, this book presents a picture of an outstanding institution in a way that makes for easy and interesting reading.



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**Contraindications:** Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine.

Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon<sup>®</sup>).

**Warnings:** **USE IN PREGNANCY:** Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

**USE IN CHILDREN:** The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

**Precautions:** It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

**Adverse Reactions:** Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.

**Dosage and Administration:** Adults — 1 to 2 tablets 3 to 4 times daily.

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# American Association of Medical Assistants

## Open Letter to Maryland Physicians

Dear Colleagues:

Without a top-notch medical assistant (or two), each of us would be sunk. You probably remember the disaster the last time your assistant was gone for a day or so!

Could your assistant be even more helpful than she is? We think so—unless you are one out of the 4% of Maryland physicians whose Girl Friday is already a member of the American Association of Medical Assistants.

What can AAMA do for you? AAMA has an on-going teaching program for medical assistants. At this month's local chapter meeting, she may learn the latest about medicare, office efficiency, better patient care, clues about telephone technique, or maybe even about malpractice prevention. AAMA encourages every medical assistant to prepare for, and to eventually qualify by examination as a CMA (Certified Medical Assistant).

AAMA is supported by the AMA and, here in Maryland, by the Medical and Chirurgical Faculty, as well as by local medical societies where chapters are active in Anne Arundel County, Baltimore city, Allegany-Garrett County, and Wicomico County. AAMA's charter prohibits it from being a union or collective bargaining agency.

Check to see if your Girl (or Girls) Friday is already an AAMA member. If so, encourage her to be active. If not, encourage her to belong. Many physicians have found the organization so beneficial that they happily pay the \$17.50 tax-deductible dues.

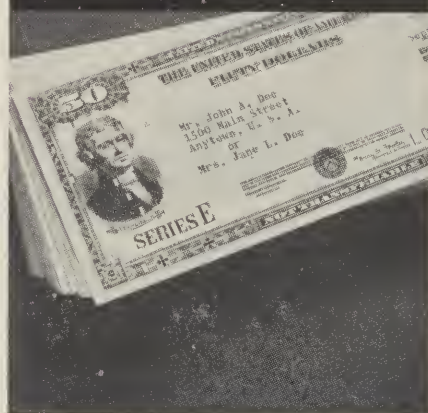
AAMA is on your side. Help boost Maryland's membership so the program can be even bigger and better. Be sure to take advantage of AAMA's program to keep your own medical assistants efficient.

The president of the Maryland chapter of AAMA is Mrs. Jean Subock, Rt. 4, 1010 Mt. Holly Drive, Annapolis, Maryland 21401.

Mrs. Dorothy Hartel, 111 Penn Street, Baltimore, Maryland, is an appointed member of the AAMA Membership Committee assigned to Maryland for membership increase.

Sincerely,  
Russell S. Fisher, MD

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**Arvo B. Ederma, MD,** and **S. Jacques Sunnenblick, MD,** both of Rockville; and **Samuel L. Fox, MD,** and **Henry L. Wollenweber, MD,** both of Baltimore, were recently installed as Fellows of the Industrial Medical Association. The installation ceremonies were held during the business session of the organization's 56th annual meeting in Atlanta, Georgia.

The association is an international organization of physicians who provide health care for the employees of private enterprises, governmental services, or other institutions. Association membership now exceeds 3,500.

\* \* \*

Four Maryland physicians were recently granted Fellowships in the American College of Cardiology. **Leonard Scherlis, MD,** of Baltimore, the ACC Governor for Maryland, listed the new Fellows as: **J. O'Neal Humphries, MD,** and **George C. Roveti, MD,** both of Baltimore, and **David L. Glancy, MD,** and **Robert I. Levy, MD,** both of Bethesda.

The college is the national medical society for specialists in cardiovascular diseases.

\* \* \*

The State Department of Health and Mental Hygiene is offering partial scholarships for specialized alcoholism training. The training will be held from June 27 to July 16, 1971, at the Summer School of Alcohol Studies at Rutgers University in New Brunswick, New Jersey. The announcement was made by Mrs. Gertrude Nilsson, Coordinator, Services to Alcoholics.

Although any qualified individual in the state who works with alcoholics is eligible to apply, top priority for financial assistance will be given to physicians, teachers, nurses, and police and correctional officers. A limited number of full scholarships are available for medical residents and interns.

## MEDICAL NEWS

For further information and an application form, write: Division of Alcoholism Control, Room 604, State Office Building, Baltimore, Md. 21201.

\* \* \*

**Richard A. Young, MD,** of Hagerstown, president of the Heart Association of Maryland, recently presented an award to two members of Maryland Blue Cross and Blue Shield.

**Reginald H. Dabney,** Blue Cross president, and **Denwood N. Kelly,** Blue Shield chief executive, received the award for their organization's educational campaigns to fight heart disease. The award was presented during the annual meeting of the Blue Cross board of directors.

\* \* \*

**David E. Rogers, MD,** and **Robert M. Heyssel, MD,** both from The Johns Hopkins University School of Medicine, recently authored an article in the *Archives of Internal Medicine*.

Entitled "One Medical School's Involvement in New Health Care Delivery Models—Its Problems and Its Pleasures", the article appeared in the January 1971 issue. It was one of several articles included in the Symposium on Social Issues and Medicine.

\* \* \*

**H. Dabney Kerr, MD,** of St. Michaels, recently received the Gold Medal award of the American College of Radiology. The award was presented in conjunction with the society's 48th annual meeting.

The award recognizes Dr. Kerr's distinguished service to radiology over a period of years. From 1930 to 1955, Dr. Kerr

was associated with the department of roentgenology at the University of Iowa. Under his direction as head of the department, the residency training program in Iowa City became highly recognized, and his students are found in important posts in radiology around the world.

Dr. Kerr was born in Catonsville and received his MD degree from The Johns Hopkins University School of Medicine.



Dr. Kerr

\* \* \*

**A. Edward Maumenee, MD,** of Baltimore, recently received a silver membership plaque from President Nixon. The award marked the launching of a nationwide membership campaign for Research to Prevent Blindness initiated by the President.

With the presentation, Dr. Maumenee, who is associated with The Johns Hopkins University School of Medicine, became the first of 10,000 eye physicians throughout the nation to be enlisted in the Ophthalmological Associates of RPB. This is part



of an intensified scientific effort to halt the rising incidence of blinding diseases.

\* \* \*

**Victor A. McKusick, MD**, chief of the division of medical genetics at The Johns Hopkins University School of Medicine, has been appointed to the National Advisory Research Resources Council.

The 12-member council reviews applications for grants from the National Institutes of Health.

\* \* \*

**Albert Owens, MD**, professor of medicine at The Johns Hopkins University School of Medicine, has been elected chairman of the medical school council. **Donald S. Coffey, MD**, associate professor of pharmacology at the medical school, was elected vice-chairman. As representatives of the council, they both become members of the advisory board.

\* \* \*

The American College of Radiology recently named four Maryland physicians as Fellows. They are: **Martin W. Donner, MD**, **Morris J. Wizenberg, MD**, and **John P. Dorst, MD**, all of Baltimore, and **James A. Lyon, Jr., MD**, of Ruxton.

The physicians were named during the college's 48th annual meeting.

\* \* \*

**Thaddeus E. Prout, MD**, of Baltimore, recently participated as a visiting lecturer at a continuing education course offered by the University of Maryland School of Medicine. Dr. Prout is chief of medicine at the Greater Baltimore Medical Center and associate professor at The Johns Hopkins University School of Medicine.

The course covered subjects in clinical endocrinology and diabetes.

Lecturers from the University

of Maryland medical school faculty included **Thomas B. Connor, MD**, professor of medicine; **Alfonso H. Janoski, MD**, assistant professor of medicine; **Luis G. Martin, MD**, assistant professor of medicine; **Salvatore Raiti, MD**, associate professor of pediatrics; and **John G. Wisell, MD**, professor of medicine.

\* \* \*

The University of Maryland School of Medicine recently sponsored a Pediatrics Day. The theme of the one-day continuing education course was medical and educational aspects of learning disorders.

Among those who spoke from the medical school faculty were: **Raymond L. Clemmens, MD**, **Marvin Cornblath, MD**, **Robert M. N. Crosby, MD**, and **Kurt Glaser, MD**.

One of the guest lecturers was **Dennis Whitehouse, MD**, director of the Diagnostic and Evaluation Clinic at The Johns Hopkins Hospital.

\* \* \*

The American Society of Anesthesiologists has elected new officers. New ASA officers in the Maryland-D. C. area include: **Chalom Albert, MD**, president; **Walter Helmig, MD**, vice-president; **Kermit H. Hanson, MD**, secretary; and **Lois F. Lee, MD**, treasurer.

\* \* \*

**John Edward Gessner, MD**, of Bel Air, has been named "Citizen of the Year." The presentation was made at the Baltimore Goodwill Industries 1971 annual awards luncheon.

Dr. Gessner received his BS degree from Loyola College in Baltimore in 1950, and his MD degree from the University of Maryland School of Medicine in 1954. He served an internship at Bon Secours Hospital and his residency at the University of Maryland Hospital.

Dr. Gessner served as director

of the Central Maryland Division of the Maryland Rehabilitation Association and was later elected to vice-president of this state group. He presently serves as director of physical medicine and rehabilitation at York Hospital in Bel Air.

\* \* \*

**William L. Stewart, MD**, of Westminster, has been appointed to a three-year term on the Commission of Education of the American Academy of General Practice.

The ten-member commission is concerned with establishing and maintaining education programs in family practice and with encouraging medical graduates to enter family practice.

\* \* \*

**Russell A. Nelson, MD**, director of The Johns Hopkins Hospital, will be the guest speaker before the **Professional Forum** at this group's monthly dinner meeting to be held on Tuesday evening, May 18, 1971, at the Baltimore Country Club.

Dr. Nelson will discuss internal problems besetting the hospital administrator today. Following his formal discussion, there will be a round-table question and answer period.

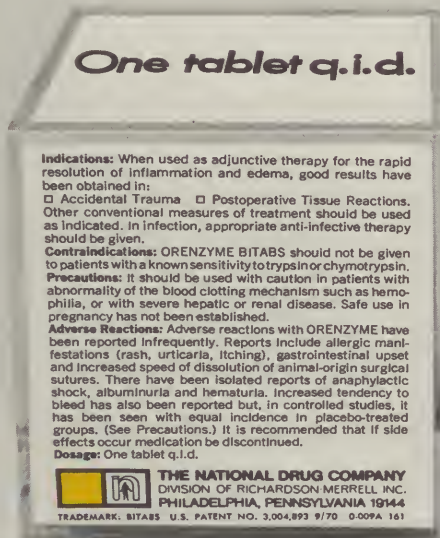
Established in 1965, the Professional Forum membership is drawn from architects, attorneys, clergymen, dentists, engineers, educators, criminologists, and physicians from the Greater Baltimore Area. It maintains close liaison with state and national professional societies throughout the country and was recently cited by the Association of American Physicians and Surgeons for its educational programs in medical economics for interns and residents.

The May program was arranged by Jack Rytten, educational coordinator for the interdisciplinary group.

\* \* \*



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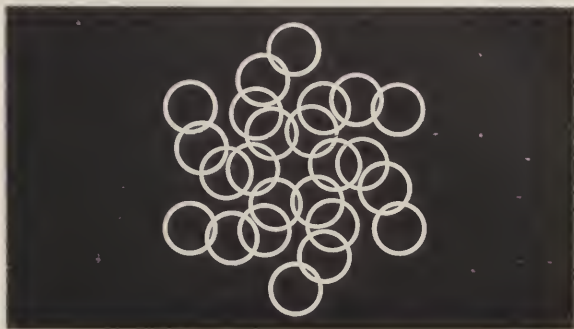


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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# Inpatient Alcoholic Rehabilitation Care

**LEONARD M. LISTER, MD**  
Medical Director  
Hidden Brook  
Rehabilitation Center for Alcoholism  
Baltimore

Alcoholism is a complex, incurable (but controllable) disease. It is characterized first by psychic dependence, next by physiologic addiction, then by physical, mental, and social deterioration, and finally by death. The exact etiology or pathogenesis is not known. There has been a great deal of investigation and analysis of prevailing clinical impressions and theories concerning alcoholism. The present consensus is that there is no single cause for alcoholism. As in so many diseases, there is a complicated interplay in alcoholism of genetic, physiological, psychological, and sociological factors. (For this reason, only 10% to 15% of the users of alcohol are ultimately victimized.) Alcohol presents acute and chronic, as well as primary and secondary, physical, mental, and social problems. The intoxicated states and withdrawal syndromes fall into the acute category. The resultant problems mentioned may be classified as primary or secondary, or both.

The patient is not responsible for having the disease, which is progressive. However, upon recognizing the disease, he is responsible for controlling it. But, there are relatively few methods of treatment to attain and maintain sobriety. Absolute and permanent sobriety must be the goal. Recognition must be sincere and motivation toward sobriety forever sustained.

Most patients deny that they are alcoholics. Defenses upheld tenaciously have carried many to total degradation or death, or both. These attitudes, as well as the proclivity of many within the medical

profession (and many others as well) in rejecting the disease concept, make it extremely difficult for the patient to recognize the disease. Development of motivation is an arduous process for the confused, uninformed, denying patient. The abnormal craving of the addict, the pain of his abstinence, and the unreasonable impulse or conditioned reflex impede the force of motivation.

These problems have impaired much therapeutic potential and are responsible for the poor statistics of sustained sobriety. Resulting frustrations have shown that inpatient rehabilitation is an important, if not essential, mechanism of treatment. Approximately 2½ years ago, with a small group of interested individuals, I helped organize a center for this purpose. As medical director, I have been very enthusiastic about our results. Continued growth and development of the center has been an education in itself.

### Organization of a Rehabilitation Center

The medical director must approve a physical structure that meets all specifications and building codes of a guest house. Beyond these health and safety standards, a comfortable retreat is desired. The suburbs, with facilities to answer most personal needs, are preferable. In this location, the patient should have little distraction or inconvenience. The home should restrict any other type of patient, for most informed individuals in the profession believe



that rehabilitation of alcoholics is best accomplished in a homogeneous environment with a group inter-associating in such a way that a form of continuous group therapy occurs in a relaxed atmosphere. The size of the group must satisfy this end. Good nutrition with freely accessible snacks and liquids, facilities for recreation, reading solitude or meditation must be available for a release of tension. The equipment and opportunity to improve physical fitness is an integral part of alcoholic rehabilitation. Any religious services should be at hand so that the patient can reconstruct spiritual affiliation and feeling often destroyed by this disease and often needed for peace of mind.

Concomitant diseases—mental, or physical, or both—with their own primary and secondary effects, may complicate or be complicated by alcoholism. Therefore, comprehensive care must always be available and medical responsibility is mandatory. New patients must be screened for communicable diseases. Any illness that the patient may have must be identified and cared for. Therefore, a general medical history and records should be obtained, and a physical examination and certain laboratory functions performed as close as possible to the time of admission. The examinations engender a feeling of protection. Any attitude of punishment, which so many patients anticipate from reactions produced while actively drinking, is dispelled. The desire to help the patient is projected and the patient begins to feel secure. This procedure gives the patient great comfort and introduces him to an environment that conveys mutual respect.

In our center, patients occasionally are admitted directly from detoxification centers or from hospitals. More often, a patient is admitted in some degree of intoxication and is very anxious, particularly about anticipated discomforts of withdrawal. Strong reassurance that comfort will be provided is essential. Whether hospitalization or detoxification would be a more appropriate disposition at that moment must be determined by the admitting personnel, usually the nurse on duty. Procedures and facilities for meticulous observation via nursing care and conservative techniques must be available. Medication also may be in order for the prevention and treatment of complications. Infection, so often present, must be treated. Anticonvulsants are given for at least one week after admission. After this time, all routine medication is discontinued, with the exception of vitamins. If at any time, disorientation or deterioration of the patient's health ensues, a program facilitating prompt transfer to a hospital must be organized. In our institution, two such incidences occurred in the period of 2½ years. Both patients returned for rehabilitation after recovery from intensive care. It is not possible or practical, because of the nature of the disease and the available facilities, to hospitalize most patients

before admission to a rehabilitation center. A physician must be on call at all times. Nursing care around the clock is indispensable.

The medical director must instill a professional atmosphere throughout the establishment and program. The entire staff must understand the disease and have compassion for the patient, react objectively, and avoid involvement in the games alcoholics are accustomed to playing. At our rehabilitation center, the patient stays a minimum of one month, but is advised to stay as long as necessary to attain maximum benefit. This minimum time was designed as the shortest period in which a comprehensive program can be offered.

It would be ideal for the patient to stay for two months, but very few extend their confinement. The program is continuous, and new patients fit in whenever they arrive. In spite of this, it is interesting that the patients report almost unanimously that their last week is the most valuable. This clearly represents their greatest achievement of sobriety and capacity to function since admission. One wonders what the reaction would be if the ideal course prevailed.

Many practical reasons are given for the patient's desire to depart after one month, which must be respected. All patients are required to sign a form contracting them to abide by the house rules at the risk of dismissal. In my experience, no patient has been dismissed for this reason. The intent is that the patient return to society free, *able to choose not to drink*, and able to begin to construct a healthy comfortable life without alcohol.

A rehabilitation program should be administered by a staff of well-trained counselors who are knowledgeable, tolerant, understanding, and able to maintain objectivity. They must be deserving of respect. There should be at least one full-time counselor for every six patients and each patient should see his counselor privately a minimum of once a week. The counselors should be respected as paramedical associates, further extending the professional atmosphere. The counselors are frequently alcoholics themselves. An advantage to this is that the patient may obtain a greater understanding of what he is experiencing (from the counselors' own past experiences, which are almost impossible to learn in depth). Furthermore, it is an inspiration to the patient to be in contact with recovered alcoholics.

It is essential that the patients learn about the disease. Each should understand alcoholism so that cooperation with professional advisors is more easily accomplished and more secure. This knowledge helps the alcoholic admit that he is a victim. All teaching devices should be employed. A library must be available and its use encouraged. Appropriate films may be shown and recordings listened to. Guest speakers offer a variety of references. Lectures on the physiologic, psychologic, and sociologic injuries



incurred as a result of drinking are described. Repetition is necessary for emphasis, so that specious preconceived notions can be destroyed.

All forms of treatment for alcoholism are described so that each patient may resort to any method needed after he is discharged. An important adjunct is the Alcoholics Anonymous philosophy which should be used and taught in detail throughout the course of rehabilitation. In this way, many individuals who would otherwise reject AA are made to appreciate its value. They see its effectiveness. Meetings should be held in the institution and the patients chaperoned to neighborhood meetings when feasible. Clearly, attendance alone is of no value, rather, the investment of feeling and active participation are necessary and rewarding. This group therapy is essential for many persons to maintain sobriety after discharge. It is of great value to the patients that they participate in the care of new admissions. This gives added continuity to the patient's return to society.

Superficial psychotherapy is also provided by means of dynamic group activity. Many techniques of group therapy are applicable. Some patients may experience psychological pain from this. However, this can be handled and directed constructively in inpatient facilities without danger by properly trained counselors. The patient will gain insight into what he must do or change in his activities, associations, or reactions, no matter how traumatic, to maintain sobriety. The group therapy approach will also help the patient break down rationalizations previously designed to excuse or explain his drinking. These procedures may be dangerous when employed in early sobriety with outpatients, as is intensive psychotherapy, for the resulting discomforts may encourage impulsive drinking or drive the patient's abnormal reactions to life situations deeper. The return to alcohol then ensues. Therefore, except in unusual patients with serious concomitant or symbiotic emotional disease, outpatient psychotherapy (except the very superficial or supportive) is contraindicated until comfortable sobriety is maintained for approximately one year. Actually, sobriety itself will relieve or eradicate much psychopathology.

Individual counseling is also provided. The patient is encouraged to analyze why he wants to achieve sobriety, rather than why he previously used alcohol. The individual is helped to develop a framework for reconstruction of his life—what he must do and how he can accomplish it. The need for a balanced life, reasonable goals, and proper use of time are emphasized.

The program is designed to allow the patient to develop a motivation based on intellect, not on fear, for the maintenance of sobriety. An attempt is made to encourage the patient to improve his ego strength by *removing* guilt and self-pity, and by acquiring a measure of self-respect, pride, and confidence.

The disease as a family problem should not be neglected. Simultaneously with the AA meetings, Al-Anon meetings are organized with spouses or appropriate relatives not only invited, but made to feel responsible for attending. They are encouraged to learn and accept the disease concept of alcoholism, and are directed to visualize and examine their own possible conscious or unconscious involvements with the patient that prevent proper control of the disease. During guest days or by special invitation, some form of family counseling is provided.

A course of rehabilitation as described provides, in a short period, what would require years to accomplish otherwise. At the time of discharge, the patient is directed to establish a proper physician-patient relationship for comprehensive care and to actively associate and participate in AA. It must be understood that although sobriety is a requirement for health and happiness, it is not a guarantee of such. Without sobriety, no problem can be solved, or any goal attained. It is advised that the patients' lives be focused on arresting the disease, until the pattern of healthy life without alcohol becomes so secure that old conditioned reflexes and false expectations are so easily controlled that the patient can begin to live with the disease.

At our rehabilitation center, all alumnae are invited to return as outpatients to participate in the program at any time. If an alumnus has maintained sobriety and finds that he is "building up to a drink", he is readmitted for a minimum of one week to prevent a catastrophe. Records are kept on each patient by the physician, nurses, and counselors.

Hopefully, rehabilitation centers as described above will become respected and recognized by the medical profession, industry, the population at large, and health insurance companies. They should be supervised by respective geographic health departments to prevent improper facilities from operating. In this way, centers would develop and be available to care for the large population of alcoholics who presently either have no such facility or cannot afford to go to one. Hopefully, alcohol counselors will develop standards of registration so that they can train and prepare themselves for much needed positions. Thus, this paramedical specialty would command the respect to which it is entitled. The profession would also protect itself from unqualified participants. I would also hope that rehabilitation centers will facilitate medical and psychological research and the training of all needed personnel (physicians, counselors, social workers, and nurses) with monies provided by grants and foundations. With this accomplished, the disease of alcoholism, one of America's greatest threats and health problems (involving six to nine million alcoholics and 30 to 40 million persons), one of society's greatest plights, and one of the sources of industry's greatest losses, would ultimately be cured.



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## THE MONTH IN WASHINGTON

**American Medical Association spokesmen urged that the AMA Medicaid national health insurance program be adopted as the best way to assure the nation's poor access to quality medical care and to free families with moderate incomes from the fear of bankruptcy resulting from a long, costly illness.**

Dr. Max H. Parrott, chairman of the Board of Trustees, and Dr. Russell B. Roth, speaker of the House of Delegates, represented the AMA before the Senate Health Subcommittee at one of its hearings on national health insurance and major health care problems facing the nation.

They estimated the first year cost of Medicaid at \$14.5 billion, much less than some proposals before Congress that would have the federal government virtually take over the nation's health care delivery.

The Medicaid legislation (H.R. 4960 and S. 987) has been introduced in Congress with 131 Democrats and Republican members as sponsors.

Dr. Roth said that Medicaid, "without disturbing the present medicare program for

the elderly . . . makes available to everyone under 65 a private program of comprehensive medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident."

Dr. Parrott warned against legislating revolutionary changes in health-care delivery. He urged that innovations be tried on an experimental scale instead.

"The American medical health-care system needs something more than a poultice, but something less than a burial," he said.

"The AMA believes we can bring about needed improvements without gambling on a whole new medical-health care system whose effects and effectiveness are unpredictable . . . The American doctor is sincerely concerned over the prospect of any sudden, single, massive unevaluated experiment which would cast all 200 million Americans in the role of the guinea pig."

Dr. Parrott also testified that many health problems would respond best to programs that are not purely medical.

"Our fat standard of living creates health problems," he said. "We ride in cars when we should be on a bicycle or on foot. We overeat. We overdrink. We smoke cigarettes. This affluent life style relates directly to the accident rate, the principal killer up to middle age, and to heart diseases, the principal killer after middle age."

Speaking as a practicing obstetrician, Dr. Parrott pointed out that infant mortality rates in this country are not entirely a medical problem. He also said that they are linked closely to malnutrition and other conditions of poverty, particularly in urban ghettos.

"If we could create a broad program that would bring dignity into the lives of people in

our slums, if we could create a world every mother wanted to bring her child into, that would do more to improve infant mortality than a hundred Mayo clinics," he said.

\* \* \*

**The chairman of the AMA's Council on Rural Health told the Senate Health Subcommittee that a variety of new health programs are needed to solve the problems of health care in rural communities.**

The AMA spokesman, Leopold J. Snyder, MD, of Fresno, California, said that some of the new programs already are being tried.

"Experience indicates that no one approach will solve the health needs of every community. Any attempt to find single causes for these health problems, or simple solutions to them, is bound to result in total frustration.

"While medical solutions are being sought, we believe that the root causes to these problems—largely socioeconomic in character—should be identified and resolved."

Dr. Snyder explained to the subcommittee that while large segments of those in rural communities have access to quality health care, there are still large segments which do not.

"In some instances," he said, "these people live in remote localities, far from the nearest health center. In other cases, their lack of adequate health service can be attributed to reasons of economics, immobility, cultural attitudes, and a host of other causes.

"Whatever the reason, the American Medical Association believes every person should have access to adequate health care, whether he lives in a city, or some remote rural region, regardless of his economic circumstances.

"Doctors are aware of the need for better health care in



rural communities. Together with other groups and organizations, we are actively developing new approaches to the problems."

Among the new programs under study by the AMA, he said, are:

—In Seattle, the University of Washington is providing former medical corpsmen with a three-month refresher course on civilian medical procedures. Upon completion of the course, these former medics are sent to physicians across the state, who have agreed to act as their preceptors, and to employ them after 12 months of on-the-job experience. Some of these men are already on the job, mostly in rural communities. This Medex Program, as it is called, is supported by the Washington State Medical Association and its Education and Research Foundation, as well as the AMA's Council on Rural Health.

—In Lawrence County, Alabama, another project also involves the services of former medical corpsmen. In this Appalachian area, there are only six physicians to serve a population of 30,000. Basically, the project has two modes of patient contact—a family care unit and "out-reach" teams. The out-reach teams introduce families to the community health service personnel, who can then begin the history-taking process and refer the family to the family care unit.

—In southern Monterey County, California, a small population is increased to 23,000 by a seasonal influx of migrant farm workers. A group of ten physicians and 80 supporting ancillary staff members have undertaken to provide medical care to all eligible residents, including migrant farm workers. Patients are cared for in the same facilities, by the same medical staff that serves the self-sustaining members of the

community. Transportation (including a van, equipped for wheelchair patients) serves the entire project area. Grantee for the project is the Monterey County Medical Society with funds from the Office of Economic Opportunity.

—Another significant approach may soon be attempted in the wilderness of southwestern New Mexico. This is a 50,000 square mile region of high mountain ranges and portions of the Chihuahua and Sonora deserts. Some 95,000 inhabitants of the region are served by only three physicians.

The program here calls for a central health center and a series of remote health stations. The stations will be staffed by persons trained in health care, but not as highly trained as a physician. They will be equipped with sensors, similar to those used by the National Aeronautics and Space Administration, to monitor the health of the astronauts. Thus, a patient visiting one of the remote health stations will have attached to himself the electronic sensors, which will transmit heartbeat, respiration, blood pressure and other vital data to the computer-controlled center, where a physician would monitor the symptoms and advise the allied health staffer by radio.

\* \* \*

**President Nixon, saying that he personally opposes abortions as "an unacceptable form of population control," rescinded a Pentagon order liberalizing the policy on abortions in military hospitals.**

His statement on abortion, issued at the Western White House at San Clemente, California, said:

Historically, laws regulating abortion in the United States have been the province of states, not the federal government. That remains the situation today, as one state after another

takes up this question, debates it, and decides it. That is where the decisions should be made.

Partly, for that reason, I have directed that the policy on abortions at American military bases in the United States be made to correspond with the laws of the states where those bases are located. If the laws in a particular state restrict abortions, the rule at the military base hospitals are to correspond to that law.

The effect of this directive is to reverse service regulations issued last summer which had liberalized the rules on abortions at military hospitals. The new ruling supersedes this—and has been put into effect by the Secretary of Defense.

But while this matter is being debated in state capitals, and weighed by various courts, the country has a right to know my personal views.

From personal and religious beliefs, I consider abortions an unacceptable form of population control. Further, unrestricted abortion policies, or abortion on demand, I cannot square with my personal belief in the sanctity of human life—including the life of the yet unborn. For, surely, the unborn have rights also, recognized in law, recognized even in principles expounded by the United Nations.

Ours is a nation with a Judeo-Christian heritage. It is also a nation with serious social problems—problems of malnutrition, of broken homes, of poverty, and of delinquency. But none of these problems justifies such a solution.

A good and generous people will not opt, in my view, for this kind of alternative to its social dilemmas. Rather, it will open its hearts and homes to the unwanted children of its own, as it has done for the unwanted millions of other lands.

\* \* \*



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**MAY 21, 1971—12:30 PM**  
**OBSTRUCTIVE PULMONARY DISEASE**

**Douglas G. Carroll, Jr., MD**  
 Associate Professor of Medicine  
 Johns Hopkins University School of Medicine  
**Stephen M. Nagy, Jr., MD**  
 Fellow in Medicine  
 Johns Hopkins University School of Medicine

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Replays: Monday, May 24, 1971 12:30 PM  
 Wednesday, May 26, 1971 7:30 AM  
 9:00 AM  
 2:00 PM

**MAY 28, 1971—12:30 PM**  
**ENCEPHALOPATHY—LEAD**

**Julian J. Chisolm, Jr., MD**  
 Associate Professor of Pediatrics  
 Johns Hopkins University School of Medicine

**Sponsor: FREDERICK MEMORIAL HOSPITAL**

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**WEDNESDAYS — 12 NOON**  
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 The Johns Hopkins Hospital

**SATURDAY MORNINGS — 8:00 AM**  
**PEDIATRIC GRAND ROUNDS**  
 The Johns Hopkins Hospital

**SATURDAY MORNINGS — 10:00 AM**  
**MEDICAL GRAND ROUNDS**  
 The Johns Hopkins Hospital



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 Easton Memorial, Easton  
 Edward McCready, Crisfield  
 Eugene Leland Memorial, Riverdale  
 Frederick Memorial, Frederick  
 Good Samaritan, Baltimore  
 Greater Baltimore Medical Center, Towson  
 Harford Memorial, Havre de Grace  
 The Johns Hopkins, Baltimore  
 Kent & Queen Anne's, Chestertown  
 Keswick, Baltimore  
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 St. Joseph, Baltimore  
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 Union Hospital of Cecil County, Elkton  
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 Veterans Administration, Loch Raven, Baltimore  
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Other locations:

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**SPECIAL INTEREST PROGRAMS**

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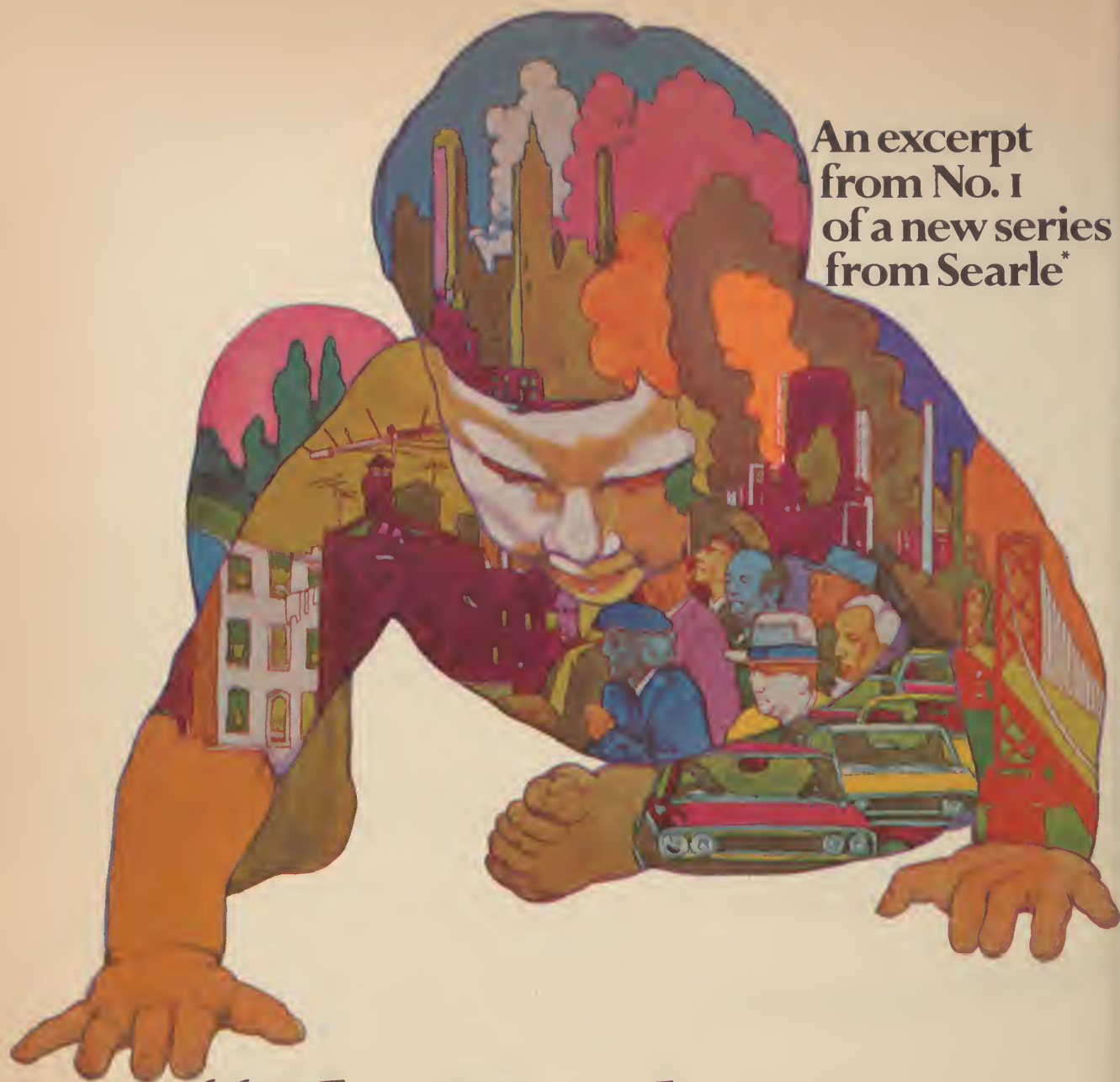
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Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
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# “The Ecology of Birth Control”

## 75 million more Americans— what impact on health care?

Because of a declining birthrate in the United States—attributable in no small measure to the widespread use of contraceptives—our population in thirty years is expected to be *only* 280 million, while the world population is expected to double, reaching 7 billion.

But the word “only” has an ironic ring to ecologists who warn of cities re-

sembling overcrowded, contaminated rat colonies, of respiratory and mental diseases reaching epidemic proportions and of a health-care community virtually overwhelmed by the burden.

The global consequences may be no less devastating. Ecologists estimate that every American has roughly fifty times the negative impact on the Earth's life-support systems of, say, a citizen of India. In these terms, adding 75 million Americans would be equivalent to adding 3.7 billion Indians to

the world population.

*\*For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative. Explored in the forthcoming issues will be the role of birth control on family pressures and its effects on the family; the influences of poverty, ethnic factors and marital status; its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.*



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**Actions**—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FHS) and the luteinizing hormone (LH).

**Special note:** Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Demulen is indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors,

some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted; anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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# Health Insurance Covers Hijacking

Accidents and illnesses occurring during a plane hijacking are covered by most insurance company health policies.

Almost all of the newer hospital, surgical and major medical insurance company policies apply anywhere on this planet, or in the atmosphere for that matter.

Hijacking is not considered an exclusion under these policies, although if the hijackings were considered an act of war, insurance benefits would not be covered.

But citizens with Medicare coverage are cautioned not to expect this insurance to pay their out-of-country medical bills.

According to Medicare provisions, an over 65 citizen requiring medical attention outside the United States is personally responsible for paying for it.

This includes, too, those tens of thousands of aged persons under social security now living abroad.

There is one exception. Should an elderly American be taken to a Canadian or Mexican border hospital (provided the emergency occurred in the United States), he could still receive benefits.

For travelers who want additional protection, short term "special risk" policies covering accidents on

trips are available. A standard trip policy usually covers from 1 to 180 days.

Benefits can be extended to include the costs of illness, too.

A typical accident-illness policy provides from \$500 to \$5,000 in additional medical benefits, and from \$5,000 to \$50,000 for death or dismemberment.

A 30-day travel-accident policy providing \$1,500 for medical expenses, \$15,000 for death and dismemberment and \$500 for luggage and personal effects loss or damage, costs under \$20. A person can insure for more if he wishes.

Should an American become ill or injured abroad and be uncertain about local medical standards, he is advised to contact the nearest U.S. Embassy or Consulate.

Should he require medical services, he will normally have to pay the bills locally. For this reason, all bills should be in duplicate. A copy should be sent to the insurance company upon arrival home, because insurance company protection continues outside the United States.

*Health Insurance News*



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## Insurers Invest in Cities

More than \$126 million in loans to build new medical facilities in run-down sections of American cities have been made by the life insurance business during the past two years.

These loans have created jobs for nearly 15,000 workers in these core areas. At the same time, an additional \$24 million for more medical facilities is now under review.

It is all part of a special billion dollar life insurance business urban investment program which grew up to \$2 billion when life insurance users pledged a second billion last year.

The largest single portion of the health facilities loans from the two programs have been for hospital construction—nearly \$75 million. Loans for nursing construction are up to more than \$44 million. Loans made for clinic construction, including modernization and additional wings, come to over \$3.5 million. Also, more than \$3.5 million has been loaned for medical office building construction.

There were 11,581 new jobs provided through loans for hospital construction, 3,022 through nursing home construction, 188 through clinics, and 116 for other medical facilities.

President Nixon described the program as one that would "have an impact far beyond what is directly accomplished by this particular investment."

*Health Insurance News*

## Women Disabled More Than Men

It costs the average woman 50% to 100% more than a man to purchase a disability income insurance policy today.

The reason, according to the Health Insurance Institute, is that, on the whole, women become ill or injured more often than men and consequently have higher disability rates.

But when it comes to life insurance the tables are turned, reports the Institute. That is, women pay less than men. The reason: At any given age females have a lower mortality rate than men.

*Health Insurance News*

## Addicting the Fetus

Recent medical research results have demonstrated that nicotine, which is absorbed into the blood stream of a smoking mother, readily crosses the placental barrier and is then introduced into the blood stream of the fetus. It follows then that the unborn child is habituated or mildly addicted to nicotine during the period of pregnancy.

*Smoke Signals*





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## Doctors Take Note . . .

*(Continued from page 6)*

**JUNE 7-9, 1971**

### **AMERICAN HEART ASSOCIATION**

Third National Conference on Coronary Care Units—New Trends and Concepts in Comprehensive Care: Fontainebleau Hotel, Miami Beach, Florida. Write: Heart Association of Maryland, 415 N. Charles St., Baltimore, Maryland 21201.

**JUNE 7-10, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course on Exfoliative Cytology in Obstetrics and Gynecology (with emphasis on the acridine orange staining technique): New York, New York. Contact: Department of Obstetrics and Gynecology, St. Vincent's Hospital and Medical Center, 153 W. 11th St., New York, New York 10011.

**JUNE 7-11, 1971**

### **CATHOLIC HOSPITAL ASSOCIATION**

56th Annual Convention: Atlantic City, New Jersey. Contact: Stephen M. Moldaver, PRSAA, Director of Public Relations, 1438 South Grand Blvd., St. Louis, Missouri 63104.

**JUNE 7-11, 1971**

### **AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Internal Medicine: Clinical Problems 1971: Shriners Burns Institute Auditorium and the University of Cincinnati General Hospital, Cincinnati, Ohio. Director: Richard W. Vilter, MD, FACP. Credit of 35 hours allowed toward AMA "Physicians' Recognition Award." Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

**JUNE 11-12, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course in Culdoscopy: New York, New York. Contact: Department of Obstetrics and Gynecology, St. Vincent's Hospital and Medical Center, 153 W. 11th St., New York, New York 10011.

**JUNE 17-19, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course in Intrauterine Development and Fetal Management: Baltimore, Maryland. Contact: A. E. Seeds, MD, Department of Gynecology and Obstetrics, The Johns Hopkins Hospital, Baltimore, Maryland 21205.

**JUNE 25, 1971**

### **DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF VIRGINIA**

Continuing Education Program—The Multiproblem Family: Boars Head Inn, Charlottesville, Virginia. For further information, write: W. D. Buxton, MD, Assistant Professor of Psychiatry, Box 190, University of Virginia Hospital, Charlottesville, Virginia 22901.

*(Continued on page 54)*



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the compound analgesic  
that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, and frustration. No doubt these psychic factors actually increased her perception of pain. Surely the last thing she needs is an analgesic containing caffeine. The logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

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**CONTRAINDICATIONS:** Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

**WARNINGS:** *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

**PRECAUTIONS:** Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

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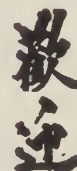
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Dr. Hall, a surgeon and former member of the widely-known DeBakey transplant team in Houston, believes that in time there will be a cure or treatment for virtually all human ailments.

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It's certain, says the Health Insurance Institute, that both health and life insurers will have to adjust their thinking and their actuarial tables, to accommodate a 175-year-old man.

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Some other routine problems were cited in "Tomorrow Through Research," a publication of the Southwest Research Institute. They include:

- How does a child treat his 200-year-old-great-to-the-sixth-power grandfather?

- What about our prison inmates? Should longevity be encouraged among those serving life sentences?

- What metallic or mineral designation would you have for a 150th wedding anniversary?

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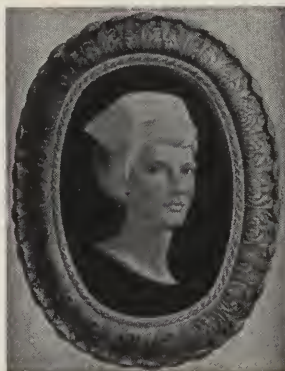
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## Doctors Take Note . . .

(Continued from page 48)

**JULY 7-15, 1971**

### AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Postgraduate Course in Venereal Disease Control: Atlanta, Georgia. Topics include epidemiology, eradication, behavioral science aspects, clinical syphilis, clinical gonorrhea, granuloma inguinale, and chancroid. There will be two sessions: July 7-10 and 12-15. Contact: James C. Lucas, MD, Assistant Chief, Venereal Disease Branch, State and Community Services Division, Center for Disease Control, Atlanta, Georgia 30333.

**JULY 22-23, 1971**

### COLBY COLLEGE

Second Annual Seminar in General Surgery: Colby College, Waterville, Maine. The seminar will discuss areas of management of trauma, vascular disease, breast disease, and problems of the biliary tract. For further information, write: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.

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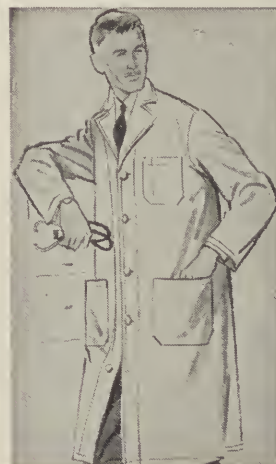
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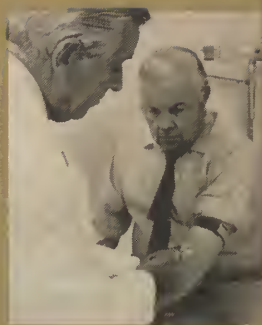
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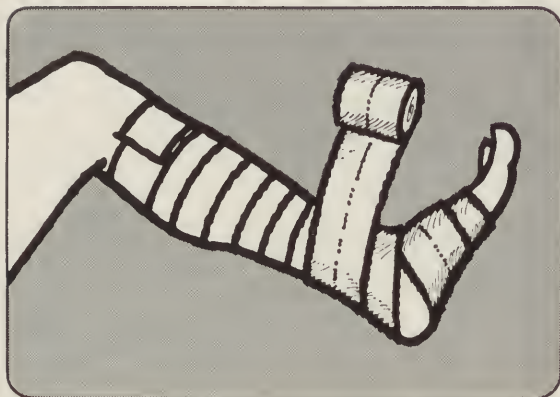
in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331.** **Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.



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MARYLAND STATE MEDICAL JOURNAL



"As long as he is healthy!" is a cliché often repeated by many expectant parents. This is still an elusive goal, however: Some 2% to 3% of all births in the United States are complicated by birth defects of various types and severity.

Sparked by the technologic advances in tissue culture, and armed with the legal means to interrupt pregnancy for fetal indication, modern medical science is on the threshold of enabling some high-risk parents to substantially increase their likelihood of bearing normal children.

# Prenatal Diagnosis

## and the

# Prevention of Birth Defects

**RICHARD H. HELLER, MD, FAAP**  
Co-director  
Prenatal Birth Defects Prevention Center  
The Johns Hopkins Hospital  
Baltimore

Traditionally, genetic disease has defied our conventional modes of therapy, but a growing number of previously devastating illnesses are now amenable to treatment, eg, galactosemia, phenylketonuria, and the adrenogenital syndrome. Nonetheless, a large

group of chromosomal and biochemical disorders remain as specific diagnostic, but untreatable entities.

Employing the technique of amniocentesis and subsequent tissue culture for cytogenetic or biochemi-



cal analysis, the door has been opened to the emerging field of preventive fetal medicine.<sup>1-3</sup>

### Amniocentesis

Performed by the obstetric member of the team, amniocentesis in the Prenatal Birth Defects Prevention Center of The Johns Hopkins Hospital is a brief, relatively painless procedure executed preferentially during the 15th to 16th week of pregnancy. The time of amniocentesis is a compromise between the increasing volume of amniotic fluid as pregnancy progresses and the technical time limits necessary for tissue culture, and the legal time limits beyond which the pregnancy may no longer be terminated.

Under the usual surgical conditions of asepsis, a 20 or 22 gauge needle is inserted directly into the pregnant uterus via the transabdominal route. Sometimes it is necessary for an assistant, working from the vagina, to manually stabilize the uterus. In order to reduce the risk of maternal cellular contamination, the first 1 to 2 cc of fluid are discarded. Then, some 10 to 20 cc of a clear, yellow-tinged fluid are withdrawn into a syringe and transferred to the appropriate laboratory. As a rule, the patients are observed for several hours after the amniotic tap.

### Complications of Amniocentesis

Maternal complications of amniocentesis are presently more potential than real. They include infection, hemorrhage, and perforation of viscera. Nationally, to date, more than 400 midtrimester amniocenteses have been performed for prenatal diagnosis, and there have been no serious maternal complications. A minor maternal complication has been the vaginal leakage of clear fluid for one to two days after the tap.

Fetal complications include direct injury, infection, and induction of labor. These hazards are also very rare, especially when the transabdominal route is used. Long-term fetal complications as a result of the procedure itself are hard to conceive and remain a matter of conjecture. It is our policy to assess all children delivered after amniocentesis on an annual basis.

A controversial maternal-fetal risk is the possibility of blood group, especially Rh sensitization in the mother, an immunologic phenomenon which must be carefully weighed when making the decision to perform amniocentesis.

Darkly-stained amniotic fluid has been observed during midtrimester amniocentesis. Its diagnostic and prognostic significance are still unclear.

One potential, but rare, source of diagnostic error—diamniotic twins—has not yet occurred, but with current methods could result in missing an affected fetus.

### Diagnostic Accuracy

Although there are differences between laboratories, most laboratories are now achieving successful cultures, ie, cellular growth and multiplication at a rate adequate for diagnostic analysis, in 90% or more of attempted amniocenteses. The reasons for cultural failure are manifold and not always clearly understood. Following cultural failure, repeat amniocentesis has been successfully performed with excellent cultural results.

Nationwide, some 50 fetuses have been diagnosed as having some disorder. In all of these, either on the abortus or in the neonate, when interruption was declined, the diagnosis was positively confirmed. This number constitutes about 15% of all pregnancies managed by amniocentesis. Of the remainder, none had the specific disorder for which the tap had been done. Curiously, this group of approximately 350 babies were all normal, except for a few insignificant structural anomalies.<sup>1</sup> One patient spontaneously aborted more than one month after the procedure, representing a rate of spontaneous abortion considerably below the norm. Thus, there were no falsely positive and no falsely negative diagnoses.

Sometimes, the purpose of amniocentesis is to diagnose fetal sex, eg, in those women known to carry a sex-linked disorder. In our own laboratory, the accuracy in sex determination has been 100%, largely due to the efforts of a modified technique of sex chromatin assessment.<sup>2</sup> The national accuracy rate is between 96% to 98% on a much larger sampling.<sup>1</sup>

### Analysis of Amniotic Fluid

1. **Supernate:** Following centrifugation of the amniotic fluid, a cellular component and a supernate may be obtained.

Already a routine obstetric procedure in the last trimester, serial spectrophotometric examination of the supernate is used to detect bilirubin-like pigment and to monitor the pregnancy at high risk for hemolytic anemia.

Serial measurement of abnormal metabolites in the amniotic fluid, or even maternal urine, has permitted the prenatal diagnosis of two disorders—adrenocortical hyperplasia<sup>3</sup> and methylmalonic acidemia.<sup>4</sup>

2. **Cells:** Although clearly of fetal origin, the exact sources of fetal cells have not been definitively established. Actively dividing cells, however, lend themselves ideally to karyotypic analysis which may be used to detect fetal chromosomal disorders or sex. Fetal sex may also be identified with a high degree of reliability by sex chromatin determination, which in our laboratory is customarily done five to seven days after amniocentesis.



By using the technique of autoradiography, it has been possible to segregate carriers and fetuses affected with the sex-linked Lesch-Nyhan syndrome, a disease due to the deficiency of hypoxanthine-guanine phosphoribosyl transferase activity.<sup>5</sup> The special significance of this technique lies in the hope of enabling carriers of sex-linked disease to abort only affected males.

The ABO blood type of the fetus may be determined by a mixed agglutination technique.<sup>6</sup> Were a specific disease known to be closely linked to a specific blood group, then one's degree of confidence in diagnosing such an illness antenatally would be increased. There is suggestive evidence that this may be the case in the Nail-Patella syndrome and congenital myotonic dystrophy.

Although collectively rare, the large group of untreatable, catastrophic enzymatic-metabolic diseases is now receiving widespread attention. Actively dividing amnionic cells, although initially epithelioid in appearance, often attain a fibroblast-like character about five to ten days after being placed in culture. These cells also lend themselves to enzymatic and sometimes histochemical analysis. Care must be taken to distinguish heterozygous carriers from affected individuals, and one cannot extrapolate skin fibroblast to amnionic cell values.

### Candidates for Prenatal Diagnosis

Unfortunately, only a small fraction, perhaps only 3% to 5%, of all known birth defects are detectable in the fetus with present techniques. Among the most blatant failures of existing methodology are the large groups of structural anomalies, eg, meningo-myelocele, hydrocephalus, phocomelia, and cardiac and renal malformations.

Here too, efforts are being made, but these are still largely experimental. Pregnancies at risk for chromosomal disorders and sex-linked disorders are listed in Tables 1 and 2, respectively. In this latter group, it is important to recall that 50% of the sons of carriers will be affected and 50% will be normal. Although in most instances of sex-linked disease, affected and normal male fetuses cannot be distinguished, in at least two disorders (the Lesch-Nyhan syndrome and Fabry's disease), this distinction can be made. Enzymatic disorders detectable in skin fibroblast and amnionic cell culture are listed in Tables 3 and 4, respectively.

**Table 1: Cytogenetic Disorders Indicating Amniocentesis**

1. Maternal (rarely paternal) trisomy, eg, Down's syndrome
2. Maternal or paternal mosaicism
3. Maternal or paternal deletions
4. Maternal (rarely paternal) translocation carrier

5. High-risk mother
  - a. Age: 40 years
  - b. Previously delivered child with chromosomal disorder
  - c. Exposure to excessive irradiation
  - d. Drugs?

**Table 2: Some Common Sex-Linked Diseases Indicating Amniocentesis**

1. Muscular dystrophy—Duchenne type
2. Hemophilia A or B
3. Agammaglobulinemia—Bruton type
4. Lowe's syndrome
5. Fabry's disease
6. Lesch-Nyhan syndrome

**Table 3: Genetic-Metabolic Disease Demonstrable in Skin Fibroblast Cultures**

Disorder	Deficient Enzyme(s)
Acatalsia I and II	catalase
Arginosuccinic Aciduria	arginosuccinase
Citrullinemia	arginosuccinate synthetase
Cystathioninuria	cystathionase
Galactosemia	galactose-1-phosphate uridyl transferase*
Gaucher's disease	glucocerebrosidase
Generalized Gangliosidosis	beta-galactosidase
Glucose-6-Phosphate Dehydrogenase Deficiency	glucose-6-phosphate dehydrogenase*
Glycogen Storage disease Type II (Pompe's disease)	alpha-1-4-glucosidase
Homocystinuria	cystathionine synthase
Hypervalinemia	valine transaminase
"I-cell" disease	beta-glucuronidase
Isovaleric Acidemia	isovaleryl CoA dehydrogenase
Lesch-Nyhan syndrome (X-linked Hyperuricemia)	hypoxanthine guanine phosphoribosyl transferase*
Maple Syrup Urine disease (Branched-chain Ketonuria)	alpha-keto isocaproate decarboxylase
Metachromatic Leukodystrophy	arylsulfatase A*
Methylmalonic Acidemia	methylmalonyl CoA carbonyl mutase
Neimann-Pick disease	sphingomyelinase
Orotic Aciduria	orotidyl pyrophosphor- ylase and orotidyl decarboxylase
Refsum's disease	phytanic acid alpha- oxidase
Tay-Sachs disease	hexosaminidase-A*
Fabry's disease	ceramidetrihexosidase

\* Heterozygote identified

From: Kaback, M. M. and Cooke, R. E.  
Sandoz Panorama, 8:4, 1970



**Table 4: Enzymes Demonstrable in Cultured Normal Amniotic Cells**

Enzyme	Potential Disease Application
Acid Phosphatase	Fetal Familial Metabolic Disorder
Alkaline Phosphatase	Hypophosphatasia
Arylsulfatase A	Metachromatic Leukodystrophy
Alpha-glucosidase	Pompe's disease (GSD II)
Alpha-keto isocaproate decarboxylase	Maple Syrup Urine disease
Beta-glucuronidase	"I-cell" disease
Cystathionine synthase	Homocystinuria
Galactose-1-phosphate uridyl transferase	Galactosemia
Beta-galactosidase	Generalized Gangliosidosis
Glucocerebrosidase	Gaucher's disease
Glucose-6-phosphate dehydrogenase	G-6-PD Deficiency
Hexosaminidase	Tay-Sachs
Hypoxanthine-guanine phosphoribosyl transferase	Lesch-Nyhan syndrome
Lactic Dehydrogenase	
Phytanic acid alpha-oxidase	Refsum's disease
6-phosphogluconic dehydrogenase	
Sphingomyelinase	Neimann-Pick disease
Valine transaminase	Hypervalinemia

From: Kaback, M. M. and Cooke, R. E.  
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### Legal, Ethical, and Moral Considerations

According to the law, 15 states and the District of Columbia permit interruption of pregnancy if the child would be born with a mental or physical handicap (Table 5). Only Virginia requires approval by the husband. In this state, Maryland, the law includes the phrase: "... substantial risk to the mental or physical health of the child", thereby leaving the assessment of the risk to the discretion of the medical profession and the couple in question.

**Table 5: States Permitting Interruption of Pregnancy for Fetal Indication**

Alaska	New Mexico
Arkansas	New York
Colorado	North Carolina
Delaware	Oregon
Georgia	South Carolina
Hawaii	Virginia
Kansas	Washington
Maryland	Washington, D.C.
New Jersey	

The provision of a safe, precise means of prenatal diagnosis certainly falls well within the scope of

high quality medical care and ethics. Similarly, the performance of a medically safe interruption of pregnancy is consistent with high professional ethics.

### Method of Procedure

Since its inception in July 1969, the center has provided clinical service to several dozen families desiring prenatal diagnosis. The center consists of a Medical Advisory Board of 12 physicians representing six medical specialties and subspecialties, a coordinator and secretary, and the laboratory facilities of the departments of pediatrics, gynecology-obstetrics, and medical genetics.

Families under consideration for amniocentesis or counseling are interviewed and then presented to the Medical Advisory Board at its biweekly meetings. The Board reviews the available data and makes specific recommendations to be subsequently presented to and discussed with the prospective parents.

The families have abundant opportunity for discussion and are under no obligation to continue with the program or follow the Board's recommendations.

Although the center is sponsored by the National Foundation-March of Dimes, operating costs greatly exceed available funds. Therefore, a reasonable fee is charged for the service performed. To date, no patients have been turned away for lack of funds. Portions of the fees are covered by some insurance plans.

No efforts have been made nor are any contemplated to remove the patient from her private obstetrician's care. Indeed, considerable effort has been expended to maintain a close working relationship with the private, referring physicians.

Referrals are accepted from local or outlying clinics and hospitals, private physicians, and directly from concerned families. Physicians and families desirous of further information about the center should address communications to:

Prenatal Birth Defects Prevention Center  
P. O. Box K  
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# The Case for Success in Narcotic Drug Addiction

**For the past several years, the subject of drug addiction and the drug addict have made dramatic headlines. Our communications media have devoted a good deal of time and space to this burgeoning social problem. Magazines, radio, television, stage and screen, and even pulpits have suddenly been made uncomfortably aware of the intensity and scope of the drug abuse problem. Not that the problem is new. But, for the first time, middle class toes have been stepped on, and the reaction has been violent.**

With all the heat generated about the addict and his habit, there has been precious little light shed on the subject. The rationale is not complex. The average addict is without funds, jobless, usually just out of prison, and friendless. Politically impotent, his cries for help remain unanswered. And, until very recently, the public has been brainwashed by the old Fu-Manchu opium horror story stereotype into imagining the average addict as a degenerate psychotic responsible for the most heinous crimes.

This stereotype is not true, says Dr. Gerald Roskin:<sup>1</sup> "Contrary to the popular mass media image of a heroin addict as a dope crazed, violent and

destructive criminal, the average addict tends to be passive, dependant, and rarely involved in violent or major crimes according to experience with over 5,000 addicts at Manhattan State Hospital in New York city. Unlike alcohol or barbiturates, which frequently stimulate the release of inhibitions and the eruption of aggressive rage leading to furious outbursts and, occasionally, to violent crime, heroin has a calming effect on the addict that makes him content and placid."

Even to the casual observer, the scramble for a successful means of coping with the narcotics problem has now become imperative. Predictably, the only response of the enforcement agencies has been



more police raids, stiffer prison terms, and a cry for more stringent legislation. Equally predictable is the same great ineffectiveness and recidivism that has been previously experienced by the identical approach to this problem in the past.

Before proceeding, it would seem pertinent to define "success" in terms of the heroin addict in relation to our modern society. Are we to call success total abstinence? If so, abstinence for what length of time? Does success mean that the addict is still in prison, on parole, in a hospital, or on a penal farm? If we mean success to be total drug abstinence of a free man in a free society, our discussion might well end here. There are simply no specifics for narcotic addiction in the entire field of pharmacology or psychiatry, or any combination of these two disciplines. Historically, the "cure" statistics (cold turkey or detoxification) are dismal: an estimated and optimistic 8%.

The Maryland Drug Addiction Commission<sup>2</sup> has said, after a lengthy investigation: "This commission has found one of the major problems in dealing with the drug dependant has *always been* the high degree of recidivism once the individual has left the controlled institutional setting. The inevitable daily frustrations the drug dependant meets upon his release result in an alarmingly high rate of return to drug usage. Such recidivism is generally acknowledged to be approximately 92%." So much for the success of our present modalities. If, on the other hand, we realistically and pragmatically call success an addict (stabilized on methadone) who has been socially rehabilitated and is now a wage earner, a law abiding family man, a productive citizen, then we have an attainable, realistic goal.

It is certainly within such a field of reference that the methadone maintenance programs have shown such brilliant promise. Drs. V. P. Dole and M. E. Nyswander,<sup>3</sup> in their New York Rockefeller Institute program encompassing a study of some 750 patients, reported some most encouraging statistics: 65% of the patients who were on the program longer than four months are working or are in school, or both. Despite rigors of the program (frequent urinalysis testing, physical examinations, monetary expenses, etc) approximately 87% of the hard-core addicts admitted over a four-year period have voluntarily remained in the program. In Baltimore, Maryland, the "Man Alive" research program, pioneered there by Dr. Emmett P. Davis, working with a group of approximately 124 hard-core addicts, has demonstrated some remarkable rehabilitative results which substantiate the New York program findings. The noted psychiatrist, Dr. William F. Wieland,<sup>4</sup> in his address to the annual meeting of the American Psychiatric Association, was most enthusiastic about his successful experiences with methadone maintenance as a vocationally and socially rehabilitative technique.

In brief, where the methadone maintenance program has been given a fair and impartial trial under properly structured disciplines, success, as we have defined it, is well within our grasp.

There is yet another dimension of success when we understand this term to mean an individual who functions as a socially acceptable individual in our community, rather than a recalcitrant human parasite whose physical needs force him into compulsive anti-social behavior. Success, therefore, begins with the drug addict who has been physiologically transferred from debilitating heroin dependency to benign methadone stabilization dependency. While admittedly an addictive narcotic (and it must be understood that we are treating only hard-core heroin addicts), the peculiar somatic properties of stabilized methadone dosage successfully prevent the usual emotional fluctuation of the euphoric "highs" and the depths of craving despair. The addict remains fully alert and physically capable. Studies by Drs. Dole, Nyswander, and Kreck<sup>5</sup> reported: "With the methadone maintenance treatment the patients have lost their craving for heroin. No patient has become re-addicted to heroin. A majority of the patients are now steadily employed. This therapeutic trial, started 2¼ years ago, is continuing."

The Man-Alive program of Baltimore, Maryland, corroborates the New York success story but uses a slightly different approach. According to the Man-Alive Program's Medical Director, Dr. Emmett P. Davis, methadone maintenance can be successful without prior hospitalization. All selected patients can be treated as outpatients, provided the following experiences are carefully evaluated, structured, and monitored. Dr. Davis<sup>6</sup> sums up his studies in the following comprehensive outline.

1. **Patient Selection:** It was found in Baltimore that less stringent entrance requirements only reduced the degree of effectiveness; ie, only hard-core drug users (four or more years of addiction) demonstrated a high percentage of cooperation over an extended period of time. When patients on probation or parole were assigned to the program by the courts as a condition of their release, they almost unanimously stayed on the treatment program until their term of conditional release expired.
2. **Dosage Levels:** Earlier attempts to keep the methadone dosage to a minimum (40 to 60 mg/day) met with disappointing results. It was determined that at least 80 mg/day and preferably 100 mg/day were required to insure the addict's continued cooperation. It was likewise determined that the blocking effect of methadone over the opiates diminished rapidly below the 80 to 10 mg/day level.
3. **Urine Monitoring:** At the outset of the Baltimore study, lack of funds prevented the appli-



cation of thin-layer chromatography on urine samples. In its place, visual inspection of likely injection sites was used. This proved to be impractical and unreliable due to certain factors such as the addict's cleverness in using obscure injection sites. It was found that the laboratory doing the testing must be competent and experienced in reading the silica gel plates. Much confusion and distrust arose when unreliable results were detected.

4. **Administration of Methadone:** Methadone administration must be accomplished on a daily basis for at least a three-month period of treatment during which time an opiate-free state is established. Then, and only then should the addict patient be entrusted with medication (methadone) outside the treatment center.
5. **Counseling:** This was found to be valuable for certain patients, and valueless for others. Attempts at mandatory group confrontation sessions met with little success. Again, lack of adequate funds prevented the utilization of trained case workers, and this affected the statistical picture adversely. At this writing, the "buddy" system as practiced in New York, combined with the presence of counselors at the clinic site, appears to be the most practical way of motivation. Job procurement and training through existing facilities such as the Vocational Training Division of the Department of Education has assured opportunity of employment wherever lacking. But, in today's affluent society, job procurement does not seem to be a problem for the motivated patient. Employers are more and more willing to accommodate people on methadone maintenance treatment. As of this writing, 109 of the 120 patients of the Man-Alive program are gainfully employed.

The main thrust of these studies clearly shows that the typically unstable, volatile, and neurotic heroin-addicted personality becomes amenable to the various counseling and training techniques used. This counseling and training are necessary to help the patient meet daily social restraints and disciplines so necessary to function in a free society. The entire emotional climate of the methadone-maintained individual becomes comparatively free of the compulsive anxiety fears induced by the consequences of drug hunger, police action, job loss, criminal activity, family repudiation, and myriad other socioeconomic pressures encountered daily by the addict. The proven ability to function physically at all skill levels including precision occupations is patently invaluable to self-esteem and peer-group acceptance. Such positive psychological advantages cannot be overestimated in the rehabilitative process.

And what of the case for drug addiction success

in economic terms? To those, and there are many, who rebut methadone maintenance with such tired clichés as: "Just substituting one addiction for another", "Methadone masks other illnesses", and "Basic emotional problems remain unsolved", it is well worth remembering that 12 cents worth of methadone in a glass of orange juice will save society at least \$250 worth of criminal activity every single day. In New York city alone, it has been estimated that addicts must raise between \$500,000 to \$700,000 a day to support their habit—most of it through shoplifting, burglary, forgery, prostitution, and other illegal activities. The New York Mayor's Advisory Council on Narcotic Addiction<sup>7</sup> estimates that narcotic addicts are responsible for at least 60% of the city's crime.

Even a casual investigation of any metropolitan police department will verify the fact that each week that an ex-heroin addict can be maintained on medically supervised methadone, society will save a minimum of \$1,500.\*

If we project this figure by the 126 addicts currently in Baltimore's "Man Alive Research Program", nearly \$2,225,000 a year is saved. It might be noted that educated guesses place the Baltimore area drug population at about 8,000 addicts. The promise of an expanded drug maintenance program can hardly be exaggerated.

Proponents of the methadone maintenance programs make no claim for cure or panacea. It would rather seem that they have substituted pragmatically successful realities for wishful, unsuccessful and unattainable goals. Methadone maintenance programs, despite being attacked with all the fervor of a religious crusade, are finding more and more professionals in all phases of the drug abuse, thoughtfully reviewing the case for success in narcotic drug addiction.

*\* The average hard-core heroin addict must steal and "fence" (at a huge discount) approximately \$1,500 worth of goods a week to get enough money for the usual \$50 a day cost of illicit drugs.*

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Lithium carbonate was finally approved by the FDA for treatment of manic-depressive illness in April 1970. In spite of the fact that side-effects are mostly minor and disappear quickly after temporarily discontinuing the drug, caution is still very much advisable since the margin between a therapeutic dose and a toxic dose is very slim.

# **Lithium Carbonate Treatment**

## **in the**

## **Manic-Depressive**

## **and**

## **Predictability of**

## **Outcome of Treatment**

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In our study at Springfield with lithium carbonate, going back to May 1968, 46 patients (22 men and 24 women) from ages 17 to 74 (average age 44), were treated within 24 months. This group included inpatients of Springfield, patients belonging to a day center, and patients being treated in private practice who were never hospitalized.

No control group was included; no placebos were used. Careful clinical evaluation of therapeutic effects and a watch for side-effects was first made each day, then every other day, and finally, twice a week. Dosage of lithium carbonate in the acute phase was increased to 2,100 mg (one capsule seven times a day), mostly ranged between 900 and 1,500 mg, and was reduced rapidly when manic excitement disappeared, usually to maintenance doses of 600 to 900 mg. Salt intake was increased and remained on that level throughout.

Blood evaluations of lithium mEq should be carried out at least two times the first week, 24 and 72 hours after the onset of treatment. Later on, weekly tests should suffice, with maintenance follow-up done once a month. All tests should be done on a fasting level.

Much in line with reports published since Cade's<sup>1</sup> paper more than 20 years ago, the influence of lithium carbonate on the manic episode became apparent within a week or two and, at the very latest, three weeks. Furthermore, the influence on the bipolar (manic-depressive) process, mitigating, postponing or excluding altogether both additional manic and depressive episodes, was quite reassuring in successful cases. While successes (39) by far outweighed treatment failures (seven), 84.8% vs 15.2%, it was the treatment failures which represent a special challenge to the treating psychiatrist.

Working in Australia in 1969, Cade's co-worker, Serry,<sup>2</sup> attempted to establish criteria for predictability of treatment outcome using a loading dose of 1,200 mg of lithium carbonate given in one dose in a hospital setting and measuring the amount of lithium excreted in the urine over the next four hours. These attempts led Serry to assume that lithium retainers—those excreting less than 11 mg of lithium in four hours—did respond well to lithium carbonate treatment. On the other hand, lithium "excretors"—those excreting over 20 mg of lithium every four hours—did not respond well clinically to lithium carbonate within 12 to 14 days.

Serry's findings, however, could not be confirmed by Stokes, Mendels, and co-workers<sup>3</sup> of the University of Pennsylvania in 1970. While a host of changes triggered by the introduction of the lithium ion has been documented by now: with total body potassium unchanged;<sup>4</sup> with sodium showing an initial decrease, followed by a rebound increase;<sup>5</sup> with adrenal cortical activity showing no significant change;<sup>6</sup> and with EEGs as reported by Platman

and Fieve<sup>4</sup> showing changes in 15 out of 28 cases, no lead as to predictability of clinical outcome has been derived so far from these studies. As yet, it is still questionable whether the goal of predictability is at all a feasible one, and whether metabolism and excretion of the lithium ion represents a test for clearance of blood by the kidneys only, or is a direct measure of some interrelation between this and the effective state. As of now, we must essentially rely on clinical supervision without predictability as to outcome on a day-by-day basis with blood tests in the beginning, at least every other day. And, clinical judgment must take precedence over laboratory findings by the photospectrometer.

The margin between the therapeutic and toxic dose is very thin clinically. Fatalities from lithium poisoning were reported in the 1940's when large doses of the drug were used in the treatment of gout. Eight cases of lithium poisoning were noted by Drs. Schou and Amdisen<sup>7</sup> in Denmark in 1953 in treatment of manic patients, in spite of increased salt intake and observation for side-effects (nausea, vomiting, fine tremors, and states of confusion, etc.), although most of these side-effects disappear between 24 to 48 hours after withdrawal of the drug.

The therapeutic level of lithium mEq should never exceed 1.7, and 1.5 should preferably be kept as the upper limit. The therapeutic dose should be reduced to the maintenance dose, immediately following the disappearance of manic symptoms, and blood levels around 0.6 to 1.0 mEq. With good clinical judgment and laboratory work carried out regularly, lithium carbonate is a safe drug. Its beneficial effects on the manic episode have repeatedly been documented in the past, ever since Dr. Cade's paper in 1949. The apparent beneficial effect on the bipolar process, including the depressive aspect, is a most welcome addendum in the management of the manic-depressive patient. Predictability, however desirable to the clinician, remains so far an uncertain future goal.

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The development of bypass grafting for coronary disease in the past three years may well prove to be one of the outstanding advances in the treatment of cardiac disease. The data are far too recent at the moment to permit more than initial evaluation, but results to date are highly encouraging.

# Bypass Grafting for Occlusive Disease of the Coronary Arteries

*This paper was delivered during the 1970  
Annual Meeting of the Medical and Chirurgical  
Faculty in April 1970.*

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Bypass grafting has been found feasible for several reasons. Most important is the fact that the majority of patients with occlusive disease of the coronary arteries, 80% to 90%, have atherosclerosis principally in the proximal coronary segments, within 5 to 10 cm of the aorta, while the distal 1 to 2 mm tributaries remain patent. These patent segments are usually found in the distal one third of the anterior descending coronary artery near the apex of the heart and near the termination of the right coronary artery at the origin of the posterior descending in the posterior interventricular groove.

Several additional features are also significant in explaining the recent evolution of this technique. Experiences with venous grafting for occlusive disease of the lower extremities over the past several years have demonstrated the durability and safety of autogenous vein grafts for vascular disease. Developments of techniques of microsurgery have made such procedures feasible with 1 to 2 mm vessels.<sup>1-2</sup> Experimental work with coronary artery surgery in the laboratory has shown these methods to be dependable in the coronary vessels of the normal dog.<sup>3</sup> The development of techniques of extracorporeal circulation has made periods of long perfusion, such as two to five hours, quite safe.

Finally, there has been an immediate improvement in cardiac function after bypass grafting, as measured by decrease in left atrial pressure of 10 to 20 mm Hg in some patients in the operating room. This immediate improvement in cardiac function after the insertion of grafts has undoubtedly been a major factor responsible for the surprisingly low mortality rate in complicated operative procedures of long duration upon seriously ill patients.

Favaloro should be credited with much of the initial work with the use of the saphenous vein for grafting.<sup>4</sup> In 1967, after extensive experience with localized endarterectomy and pericardial patch grafting, short segments of saphenous vein were inserted in occluded areas of the right coronary artery. With experience, longer and longer segments were employed.<sup>5</sup> Soon thereafter, Johnson and associates<sup>6</sup> in Milwaukee, Adam and associates in Dallas, and Green and Tice at New York University began to employ different modifications for grafting. Green first used the dissecting microscope to anastomose the internal mammary artery to the apical portion of the anterior descending coronary artery in 1968.<sup>7</sup> In all groups, the impressive preliminary results quickly heightened interest and enthusiasm, leading to the rapid application of similar operative procedures in additional patients.

### Indications for Operation

At the present time, coronary arteriography is recommended for the majority of patients with severe angina pectoris. In most of these patients,

advanced stenosis or occlusion of one or more of the major coronary arteries will be found. Usually, significant obstruction—more than 75% narrowing of the lumen—will be found in more than one of the three major coronary arteries, either “double” or “triple” disease. At present, the demonstration of obstruction of a major coronary artery has been the principle guide for operation. Neither absence of visualization of a patent distal segment, nor the small size of the distal coronary artery have been found to be valid contraindications to operation. A patent distal segment may not visualize because an inadequate amount of dye enters the lumen through collateral circulation. A segment that appears unusually small on angiography, with an internal diameter seemingly in the range of 300 $\mu$  to 500 $\mu$ , has been found at operation to dilate readily with calibrated probes to a diameter of 1 to 2 mm.

Left ventricular end diastolic pressure is an index of cardiac failure but has not been found a contraindication to operation, although the operative risk is somewhat increased. Patients with moderate angina often have a normal end diastolic pressure (upper limit of normal is 10 to 12 mm Hg), but those in cardiac failure may have an end diastolic pressure elevated to 20, 30, or even 40 mm Hg. One of the best measurements of immediate improvement in cardiac function has been the demonstration in the operating room of a decrease of 10 to 20 mm Hg in diastolic pressure following bypass, when compared to that before bypass.

Left ventricular angiography is an important component of preoperative studies, indicating the degree of impairment of contractility of the left ventricle, with scars from aneurysms, akinetic segments, and left ventricular aneurysms. Widespread diffuse impairment of contractility from extensive destruction of left ventricular muscle and subsequent fibrosis is the most ominous preoperative finding. Sufficient experience has not yet been obtained to permit exact interpretation of impaired contractility, for ventricular function has improved in some patients with marked preoperative impairment of contractility, while others have shown little change. At present, left ventricular angiography holds the most promise of being the most important preoperative test in estimating the likelihood of improvement following operation. In the past nine months, over 90% of a group of approximately 60 patients with angiography were found to be operable, using the criteria described above.

Coronary angiography has similarly been found to be an important adjunct in the management of patients with left ventricular aneurysm. A left ventricular aneurysm develops in 10% to 15% of patients following myocardial infarction from occlusion of a major coronary artery. If the coronary atherosclerosis is principally in the vessel supplying the heart where the aneurysm develops, there is little



potential for revascularization. However, patients often have other areas of occlusive disease in the remaining coronary arteries supplying the residual functioning left ventricular muscle, and concomitant revascularization of these areas with bypass grafts may be done when the aneurysm is excised.

### Operative Technique

Operation is performed with cardiopulmonary bypass, using a Bentley oxygenator, with approximately 50% hemodilution, at a flow rate near 2.5 L/M<sup>2</sup>/min, and a temperature of 30 C. Aortic cannulation is routinely done for arterial perfusion, and the left ventricle is decompressed throughout the operation with a cannula inserted either through the apex of the left ventricle or through the left atrium. The heart is stilled by either electrical fibrillation or by intermittent clamping of the aorta for ten to twelve minutes, alternating with three to five minutes of perfusion.

**Figure 1:** Photograph of binocular loupes which have been found useful for operation on coronary arteries. The microtelescopes, which are mounted in lenses which may be corrected for the individual surgeon's use, magnify to 4 power, and have a focal length of 16 inches and a depth of field of 4 inches.



An arteriotomy about 1 cm in length is made, after which the lumen of the artery proximally and distally is gently dilated with soft, malleable specially designed silver probes, which are calibrated from the range of 0.5 to 3.0 mm. The probes are inserted proximally and distally as far as possible, dilating the artery to permit a greater flow of blood after grafting. The surprising and critical feature of coronary vessels is the ability to dilate them significantly at operation. Apparently, a vessel distal to an area of occlusion becomes contracted from decrease in arterial pressure and from surrounding fibrosis, for a tiny vessel, less than 1 mm in internal diameter initially, may dilate readily to an internal diameter of 1.5 or even 2.0 mm. This is the technical reason that preoperative estimation of diameter of the distal vessel as seen on angiography has not been found a valid guide to the feasibility of operation.

A segment of saphenous vein previously removed

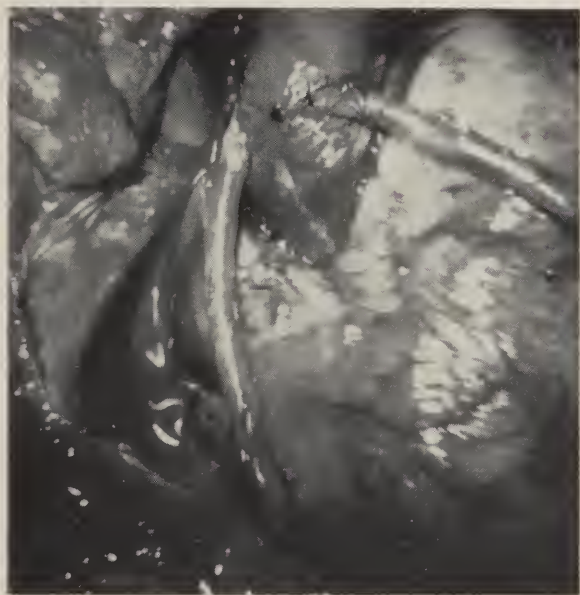
Optical magnification is usually employed. The most useful magnification has been a four-power magnification with specifically designed loupes, which permit the surgeon to either look through the loupes for magnification or around them for a normal view of the field of operation (Figure 1). Alternately, the dissecting microscope, magnifying up to 10 to 16 power, which has been developed principally by Green, has been used. The optical loupes have been found satisfactory for the majority of patients. Dissection is initially performed over the distal third of the anterior descending coronary artery near the apex of the heart, locating the artery in the epicardial fat and tracing it proximally until disease is found. Usually, the external diameter of the artery is in the range of 1 to 2 mm. An attempt is made to limit dissection to the anterior surface of the artery, avoiding mobilization of the artery from its epicardial bed because of the increased fragility and risk of hemorrhage when the artery is sutured.

from the right thigh is reversed and an oblique end-to-side anastomosis is constructed with continuous 6-0 Tefdek suture. After completing anastomosis, a clamp is applied to the graft proximal to the anastomosis so interruption of any blood flow through the coronary artery is limited to 20 to 30 minutes.

The graft is then attached to the aorta proximally, leaving enough slack in the graft so that there is no tension whatever. The graft is usually attached to the left anterolateral surface of the aorta so the angle of junction of the graft with the aorta is either a right or obtuse angle. An anastomosis forming an acute angle with the aorta is avoided because of the increased turbulence. The aorta is incised for about 2 cm, after which the anastomosis is again performed with continuous 6-0 Tefdek. Excision of an ellipse of aorta, done with an earlier technique, is carefully avoided because of apparent distortion and stretching of the vein from excision of the segment of aortic wall.



The right coronary artery is normally dissected near the origin of the posterior descending artery in the posterior interventricular groove. The vessel is almost always patent at this area, even though occlusion of the right coronary may extend up to the origin of the posterior descending. The frequent finding of a patent posterior descending is somewhat reminiscent of the similar frequency of patency of the profunda femoral artery in the thigh, despite the presence of extensive occlusive disease in the aorta, iliac, and common femoral arteries. The vein graft on the right is then attached to the right anterolateral surface of the aorta. Anastomosis of one vein graft to the other, followed by a single aortic anastomosis, was done with an earlier technique, but separate anastomoses to the aorta are now preferred (Figure 2).



**Figure 2:** Operative photograph showing double venous bypass grafts between the aorta and coronary arteries. The graft from the left, arching over the pulmonary artery, goes to the distal anterior descending coronary artery. The grafts are attached obliquely to the aorta to minimize turbulent flow. The graft from the right was attached to the right coronary artery posteriorly.

Experience with the circumflex coronary artery is limited at present. It is usually exposed in the atrioventricular groove, mobilizing the adjacent vein. The exposure is considerably more difficult than with either of the other two coronary vessels. An important future question is whether a double bypass of the anterior descending and the right coronary arteries will not suffice for the majority of patients or whether a triple bypass to all three major coronaries is necessary.

In a significant number of patients, the left internal mammary artery has been mobilized and anasto-

mosed to the anterior descending coronary. This technique has been developed principally by Green.<sup>8</sup> The internal mammary artery is technically more difficult to use than the saphenous vein because of its small size and fragility. It is also smaller in diameter than the saphenous vein, but the principle determinant of blood flow after operation is the diameter of the coronary vessel, usually significantly smaller than the graft. The internal mammary artery is preferred because the anastomosis is made between two arteries of similar size and hence may have a higher patency rate in the future than venoarterial anastomoses. This is an important question for future studies. The flow rate has usually been determined in the operating room after bypass is stopped, applying electromagnetic probes to the grafts. The rate of flow has varied widely, from as little as 20 to 30 ml/min to as high as 100 to 150 ml/min. The rate of flow, of course, varies with the size of the coronary vessel, the size of the graft, the systemic pressure, the cardiac output, and other factors. In 26 patients operated upon by Green and Tice with the internal mammary artery anastomosed to the anterior descending, flow ranged from 12 to 88 ml/min, averaging 50 ml/min. Flow rates following vein grafts have been somewhat higher, averaging 60 to 80 ml/min. Whether these differences are significant is unknown at the present time.<sup>8</sup>

Left ventricular scars of significant size, usually identified by ventriculography before operation, are excised at the time of operation if significant paradoxical contraction is present. Excision is limited to the area of visible paradoxical contraction, easily identified by palpation of a thin, parchment-like segment of fibrotic left ventricular wall. Once this has been incised to enter the lumen of the ventricle, palpation of the thickness of the wall of the ventricle is a useful guide to outline the area for excision. The usual size of the segment excised has ranged from 5 to 8 cm in length, to 3 to 5 cm in width. The ventricle is closed with heavy Dacron sutures buttressed with Teflon felt, followed by a continuous suture.

In some patients in severe cardiac failure, serious mitral insufficiency has been present, manifest clinically by an apical systolic murmur and demonstrated on catheterization by extensive reflux of dye into the left atrium following injection into the left ventricle. The genesis of the insufficiency is apparently dysfunction of the papillary muscles and the left ventricular wall, for the mitral valve appears surprisingly normal when exposed with an incision in the left atrium. The leaflets are normally supple, minimal dilatation of the annulus is present, and the chordae appear normal without any ruptured chordae. Visible scars may be seen in the papillary muscles, but these are not impressive.

The proper management of this insufficiency is



not yet certain. The degree of impairment of cardiac function from the insufficiency seems to prohibit not correcting it at operation. Annuloplasty appears the preferable technique, but whether the results of annuloplasty will be durable with the diseased tissues is yet unknown. Prosthetic replacement of the mitral valve, of course, is the most certain method of repair, but one is naturally reluctant to excise a mitral valve with normal leaflets and chordae. Annuloplasty has been performed in most of the few patients operated on to date, but recurrence of the insufficiency has developed a few weeks after operation in at least one patient.

The role of arterial implants into the myocardium, the Vineberg operation, has progressively decreased in our experience. The natural combination of operations is to perform a bypass graft when feasible, and to perform an arterial implant into an area of ischemic myocardium where revascularization cannot be done. With increasing experience, an anastomosis has been possible in the vast majority of patients. Only one arterial implant has been performed in a group of 40 operations done in the last six months.

#### Postoperative Care

Before the sternotomy incision is closed, small polyvinyl catheters are placed in the left atrium and pulmonary artery and brought through the chest wall for monitoring for two to three days. The monitoring of left atrial pressure, and oxygen saturation of mixed venous blood obtained from the pulmonary artery have been found invaluable after operation. Blood is transfused in appropriate amounts to keep the mean left atrial pressure in the range of 20 to 25 mm Hg if the cardiac output is not adequate, as indicated by the oxygen saturation of the mixed venous blood. The exact level of left atrial pressure maintained depends on the degree of elevation of left atrial pressure before operation. If cardiac output is inadequate despite transfusion of sufficient blood to elevate left atrial pressure to 20 to 25 mm Hg, intravenous catecholamines and glucagon are given, usually epinephrine or isoproterenol hydrochloride (*Isuprel*), 1 to 2 mcg/min for 24 to 48 hours.

Constant visual monitoring of the electrocardiogram on an oscilloscope is equally important, for arrhythmias are frequent and unpredictable. A wide variety of arrhythmias have occurred, including atrial fibrillation, tachycardia, nodal rhythms, and ventricular premature contractions. The unpredictability of the arrhythmias requires constant observation and different methods of management, including digitalis, procaine amide, lidocaine, propranolol, potassium, and electrical cardioversion. Arrhythmias may occur for several days after operation, but are more frequent in the first 48 to 72 hours.

Digitalis is given as indicated by the degree of

cardiac failure present. Mechanical ventilation is usually performed through an indwelling endotracheal tube for 12 to 18 hours after operation, but a tracheostomy is infrequently necessary. Antibiotics are routinely given for about one week after operation. Anticoagulants are begun four to five days after operation because of the frequency of phlebitis in the extremity from which the saphenous vein was removed. These are usually stopped when the patient is discharged from the hospital 12 to 18 days after operation. There is no evidence at present to suggest that anticoagulants influence the long-term patency of the bypass grafts.

#### Results

The first bypass procedure was performed at New York University by Green and Tice in February 1968, anastomosing the internal mammary artery to the anterior descending coronary artery. At present, 81 patients have been operated on, with eight operative deaths and five late deaths. The internal mammary artery was used in 41 patients, while in 25 others the saphenous vein was anastomosed to the left anterior descending. The saphenous vein has also been used as a bypass graft in 57 anastomoses to the right coronary artery and six to the circumflex coronary artery. Single grafts were used in 34 patients, double grafts in 45, and triple grafts in two. The causes of the 13 deaths, both early and late, were myocardial infarction in three patients; pneumonia, cardiac arrest, and pulmonary embolus in two patients each; hepatitis in one patient; and thrombosis of the superior mesenteric artery in one patient. Two patients died suddenly at home; the cause of death could not be identified.

There has been a gratifying relief of angina in virtually all patients, and significant improvement in signs of cardiac failure in several. Angiograms performed two weeks to 19 months after operation in 25 patients found at least one patent anastomosis in 24 patients. Thrombosis of one venous graft in patients with double or triple grafts was found in five patients.

#### Data Reported by Others

Favaloro reported in 1970<sup>5</sup> that saphenous vein grafts had been used in 224 patients between May 1967 and February 1969, with ten hospital deaths. Only a few patients were studied a year after operation; the usual finding was a patent venous graft without any dilatation. Johnson<sup>9</sup> has reported experiences with over 100 bypass grafts in a series of 301 patients operated on since February 1967, with a mortality of 12%.<sup>9</sup> Double grafts were inserted in 40% of the patients. Forty-seven were studied by angiography, usually before discharge from the hospital, finding 44 patent grafts and three occluded. In November 1969, Adam and associates reported experiences with 80 patients operated on



since January 1968, inserting a total of 133 grafts.<sup>10</sup> The operative mortality was 11%, with one death occurring after discharge from the hospital. Eighty percent of the patients remained asymptomatic after discharge from the hospital. Angiography in 28 patients found a patent graft in 23.

### Discussion

Significant data with bypass grafting have been accumulating only in the past two years, and techniques of operation are still evolving. Hence, only preliminary conclusions are possible at this time. It is clear that a majority of patients with coronary artery disease, probably in the range of 80% to 90%, can be considered for bypass grafting. Anastomoses can be performed with reasonable certainty to coronary arteries as small as 1.0 mm in diameter. The operative mortality, originally near 10%, has decreased to less than 5%, a surprising finding in the presence of serious coronary atherosclerosis. Angina is immediately relieved in the majority of patients. One of the most dramatic experiences in cardiac surgery is the prompt elimination of severe angina in patients previously taking over 100 nitroglycerin tablets a week. Immediate patency rate of grafts is higher than 90%. Patients with serious cardiac failure, formerly unsuitable for any type of cardiac operation, may be dramatically improved after operation, but only limited data are yet available with this group of patients.

**Current Questions:** A large number of important questions remain for the future. The major one is the long-term patency of the grafts. Occlusion may occur because of the small size of the vessels or from progression of the underlying disease—coronary

atherosclerosis. Continued patency for two to three years in a small group of patients is encouraging at the present time. A second important question is the protection from myocardial infarction and death in patients with patent grafts. Several questions regarding technique need further consideration, including the use of the saphenous vein as compared to the internal mammary artery, the role of optical magnification at operation, and the indications for single, double, or triple bypass grafts. Finally, the adjunct of arterial implants into the myocardium requires continued reassessment. Undoubtedly, the majority of such implants remain patent, but the rate of blood flow in many has been disappointingly small.

**Future Considerations:** Several areas of laboratory investigation will surely produce important additional methods of therapy in the near future. These include the performance of emergency coronary angiography, followed by emergency bypass grafting in patients with impending infarction. The question of emergency excision of acute myocardial infarcts associated with shock or intractable arrhythmias has undergone preliminary clinical trial in a few patients but has an uncertain role at present. A satisfactory pump which could be implanted between the left ventricle and the aorta for several days or weeks, after which it could be removed, could be greatly beneficial. The appropriate combination of several of these methods of therapy may be used in some patients, including emergency angiography, bypass grafts, excision of acute infarcts, and temporary left ventricular-aortic pumps. It is clear that bypass grafting has inaugurated a new era in cardiology, the magnitude of which may be very great indeed.

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# **your medical faculty at work**

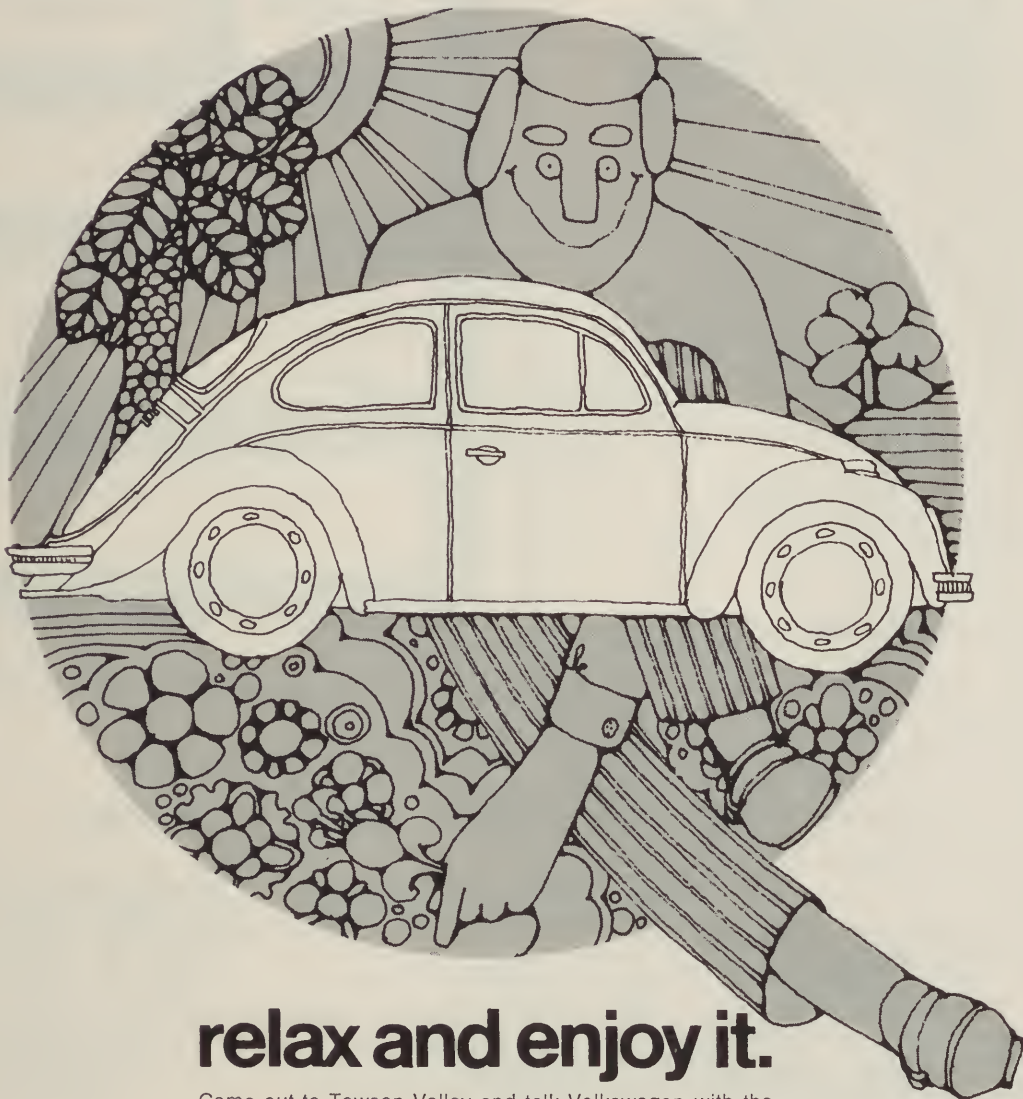
**by John Sargeant**  
**Executive Director**

**The Council met on Thursday, March 25, 1971, and took the following actions:**

1. Recommended various physicians for emeritus membership to the House of Delegates, at the request of the components involved;
2. Waived 1971 dues for two members because of illness, on the recommendation of the component societies involved;
3. Adopted Columbus Day as a regular holiday for closing the Faculty building, in accordance with new, revised federal holiday schedules;
4. Approved a \$50 contribution to the School Health Conference of the Maryland School Health Council;
5. Approved offering inclusion of component society officers and committee members in the Faculty's libel and slander insurance policy, provided such components underwrite the expense involved;
6. Authorized the Executive Committee to submit additional nominees to Maryland Blue Shield for appointment to the Blue Shield Reference and Appeals Committee;
7. Approved a program for regionalization of peer review activities within the state, as recommended by the Peer Review Committee;
8. Reiterated action of the Executive Committee taken in October 1970, dealing with Duties and Responsibilities of Medical Directors for Nursing Homes, Extended Care Facilities, and Related Institutions. The Council also instructed that the Maryland Health Facilities Association and the State Department of Health and Mental Hygiene be notified of this action, and instructed the Peer Review Committee of the Faculty to implement this in conjunction with peer review activities on a regional basis;
9. Heard a progress report from the Public Relations Committee chairman on meetings with medical school deans and U. S. senators from Maryland. The subject of the meetings concerns increased enrollment in the medical schools, funding for this, and use of community hospitals for teaching purposes;
10. Approved a questionnaire to be sent to all members in a separate mailing dealing with Blue Shield and its relationships to the public and physicians. The contents of the questionnaire will be discussed and revised by the Executive Committee;
11. Approved a \$150 contribution to the Student AMA chapter at The Johns Hopkins University School of Medicine;
12. Heard about a conference on health quackery, particularly chiropractic, to be held in Washington, D. C., on Friday, May 7, 1971;
13. Authorized contacting the Food and Drug Administration urging that the policy decision on combination drugs be deferred indefinitely, or until the medical profession has some input on the subject;
14. Agreed to provide consultants to the State Department of Health and Mental Hygiene to deal with an air pollution problem in the Cecil County area;
15. Authorized releasing the report of the Faculty's actuarial study dealing with professional liability insurance to the St. Paul Companies, and instructed that a copy be sent to the State Insurance Commissioner;
16. Authorized attendance of the Faculty's actuary at the meeting scheduled with representatives of the St. Paul Company to discuss further changes in the premium structure for the professional liability program;
17. Determined that it would request an audience with the Governor to discuss activities of the state's Comprehensive Health Planning Agency.



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## library

# Impressions of a Book Auction

Back in February, following the sorting, selecting, and weeding project this library has been undergoing for several years, we attended our first auction of "rare" books in New York city. Since Med-Chi's part of this particular afternoon's auction was to start at 3 PM, we planned to arrive at the Swann Galleries on 24th Street about 2 PM to observe an auction of limited miscellaneous editions.

"Galleries" suggested a rather elegant atmosphere, and although we had been warned that this was not the case, we were nevertheless a bit surprised when the taxi stopped at what appeared to be an empty warehouse in an obviously lower rate commercial section of the city. However, we found our way to the fifth floor and a small auction room reminiscent of many secondhand bookstores of decades ago.

Books were arranged according to the two auctions to take place that afternoon, and alphabetically by author except where several titles with some

vague relationship to each other were grouped together in "lots". We listened to the humdrum recital of titles and bids for an hour, until our own collection came up. Then it was similar to seeing, or rather hearing, old friends being sold to the highest bidders.

Compared to auctions of rare antiques, this was an emotionless procedure, though at times the bidding proved fairly lively. Rather than individual bidders, most of the 35 to 40 people there who were doing most of the bidding were dealers, or interested librarians and other professionals. The auctioneers made no effort to create an interest in any particular title, taking for granted that all those interested had reviewed the collection and knew exactly what they wanted beforehand.

We came away wondering just how much we had gleaned financially and where our old book friends would eventually land!

## NEW ACCESSIONS—BOOKS

(Arranged by Subjects)

### CRIMINOLOGY:

Zimring, Franklin E.

**Perspectives on deterrence.** Washington, National Institute, Center for Studies of crime and delinquency, 1971. HV 6080 Z5 1971

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**Deterioration and preservation of library materials.** Chicago, University of Chicago Press, 1970. Z 700 C4 1970

Chicago. University. Press.

**A manual of style.** Chicago, University of Chicago Press, 1969. Z 253 C4 1969

### MEDICAL CARE, HOSPITALS, NURSING HOMES:

American Society of Internal Medicine.

**Changing concepts in the delivery of health services.** 13th annual meeting program sessions, April 19, 1969, Chicago. W 76 A5 1969

Commission on Professional and Hospital Activities.

**Length of stay in PAS hospitals, U.S. 1969.** Ann Arbor, Mich., 1970. WX 16 C6 1970

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**A biographical history of medicine:** excerpts and essays on the men and their work. New York, Grune & Stratton 1970. Ref. WZ 112 T 2 1970

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## Baltimore City health department

# Dr. De Hoff Appointed Chairman of National Health Records Committee

John B. De Hoff, MD, MPH, Deputy Commissioner of the Baltimore City Health Department, has been named Chairman of the Program Committee for the Second Annual Conference of the Association for Health Records to be held in Washington, D.C., June 18-19, 1971. This is one of several committees planning the session, whose overall theme is "Individual Health Records—The Heart of the Matter."

Specific areas to be covered at the conference will include the role of the health records analyst, individual health records, health records for institutional management and management of groups of patients, and health records as a source of information for community or regional uses.

The Association for Health Records was founded in 1969 to provide a multidisciplinary forum for the exchange of information among all persons in the field of medical and health records. It maintains an office at Ann Arbor, Michigan. Co-chairmen of the conference are Keith W. Sehnert, MD, of Arlington, Virginia, and Philip N. Reeves, MD, Research Coordinator, Department of Health Care Administration, The George Washington University, Washington, D.C.

Dr. De Hoff's participation in this program will be highly advantageous to the health of Baltimore. Through his participation, the department will have an opportunity to review the latest professional thinking on health records and to institute any needed changes that would reflect benefits to the city and the people served.

Health records are used in many fields, from

health districts and health centers to hospitals, well-baby clinics, schools, and handicapped children, and many environmental activities. Currently, the department is working on comprehensive records following pregnant women through the birth of their babies and the child's growth and development. The records system includes birth and death certificates and much that transpires in the health of our citizens during their lives.

Furthermore, the department is interested in a coordinated health care record system because of special clinics like alcoholism, geriatric evaluation, and evaluation of the quality, necessity, or availability of care. These records and records management systems are under constant review and it is hoped that participation in such organizations as the Association for Health Records will help improve the health status of our city.

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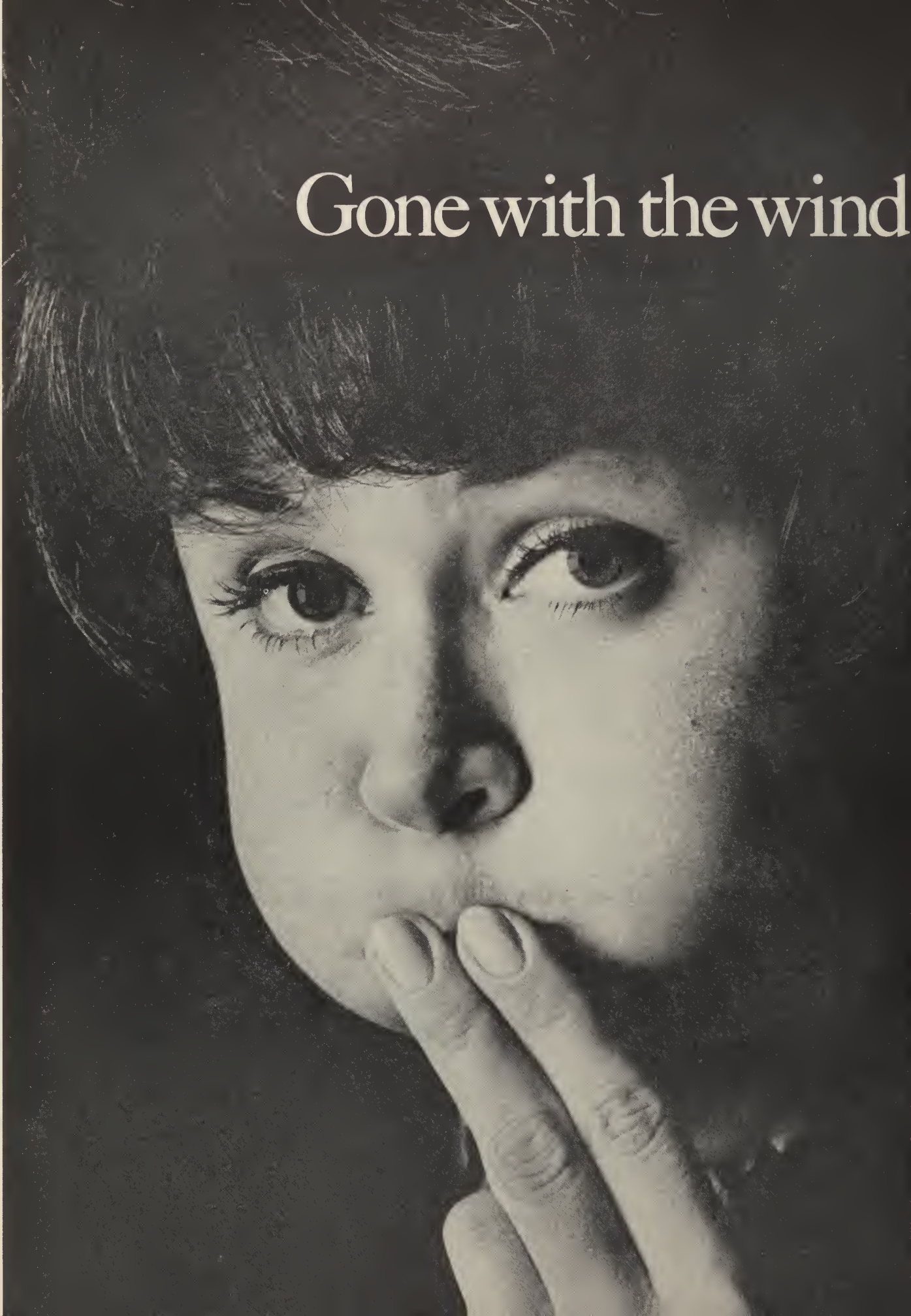
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\*Slinger, A.: Med. Times 94:150 (Feb.) 1966.

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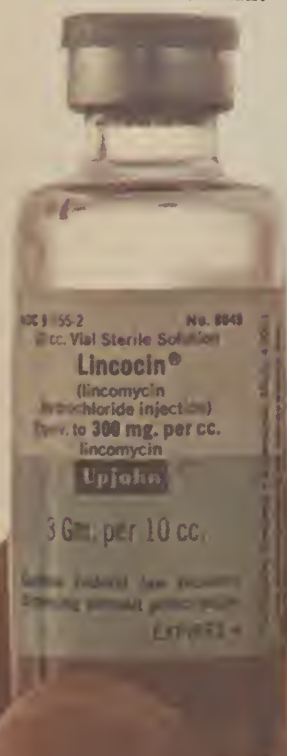
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## rehabilitation notes

# Patterns of Medical Care in a Municipal Hospital

In the past several centuries, the major advances in medicine have been brought about by improved precision of observation and measurement in chemistry, microbiology, and physiology. Diagnosis and therapy have been foremost. The results of treatment have generally been judged in terms of survival rates. In hospital charts, the final results are categorized in terms of "improved, unimproved, dead". These categories have been used because no more precise instruments are available for judgment on what results have actually been obtained.

A number of emerging influences are forcing us to be more precise in judging the results of hospital care. Rehabilitation results do not easily fall into the rubrics of "improved, unimproved and dead". Most patients who undergo prolonged rehabilitation do not die, nor are they cured. Results should be judged in terms of the patient's total adjustment to his disability, family, vocation, and self-care.

Third-party payors are also asking for more precise results of hospitalization, what services are being received, and whether these services are really helping the patient.

Finally, the public is also looking at the cost of hospitalization and questioning the expense and what is being accomplished.

Thus, it seems imperative that we begin to think of hospital accomplishment in terms of the total effect of the experience on the patient—performance, control of the disease, psychological effects, effects on the family, and return to gainful employment.

A second need is improved precision in prognosis for performance. Is it possible to select better those patients who will profit from long and expensive hospitalization?

In previous "Rehabilitation Notes", we have been

interested in seeing what happened to patients in various categories who were hospitalized in a municipal hospital. The criteria developed for judging success of hospitalization has been based largely on performance of activities of daily living, whether the patient returned home, and whether he was readmitted to the hospital. These are new criteria for judging hospital success and need to be defined more precisely. It has been our purpose to demonstrate that such criteria can be set up and used to evaluate hospital success.

In previous "Rehabilitation Notes", we have examined five different patterns of medical care rendered in a municipal hospital.

1. In the first,<sup>1</sup> we examined the accomplishments of hospitalization in a group of patients recognized to have chronic disease and, on admission, presumed to need primarily prolonged nursing care. From this study we concluded that many patients (27%) in this group could actually return to their homes and that potential for rehabilitation (in terms of discharge to home) could not always be recognized at admission (79% of those actually discharged did not seem to have this possibility on admission).

2. In a second communication,<sup>2</sup> we examined



some of the accomplishments of an intensive care unit where new technical procedures are available for patient treatment. In this study, we used the mortality rate of patients with various diseases as an indication as to how effectively an intensive care unit functioned.

3. In a third communication,<sup>3</sup> we examined the results of rehabilitation in patients referred from the Acute Services to the Department of Physical Medicine and Rehabilitation for evaluation and treatment. We used as a criteria for improvement the Activities of Daily Living scores performed serially.

4. In a fourth communication,<sup>4</sup> we used the same method to follow the course of functional change in Activities of Daily Living over a prolonged period of time, using patients in a chronic disease hospital.

5. A fifth communication<sup>5</sup> concerned readmission of patients to an acute medical service during a four-month period. The reasons for readmission were analyzed. Improved follow-up was identified as the process which might be most amenable to change in the interest of improving patient management.

A number of other studies of patient care have originated in this hospital, concerned with the Chronic Hospital,<sup>6</sup> Emergency Room,<sup>7-8</sup> and a recent study of discharged patients.<sup>9</sup> All of these studies have been concerned with setting up criteria for evaluation of medical care accomplishment.

### Discussion

In both the United Kingdom and the United States, there has been a decreasing mortality rate at all ages. The figures are very close in the two countries. If taken at five-year intervals, however, one notes that during the last ten years, there has been no significant drop in the mortality rate. This seems to indicate that we have reaped the benefits of the antibiotic era and can expect little improvement in mortality rate from the discovery of new drugs. This opinion is supported by the obvious increase in chronic disability and hospital admissions, the increasing time and expense of such special procedures as care in the intensive care unit, transplants of kidneys, dialysis, and cardiac transplants.

Future efforts to improve medical care will have to be aimed toward controlling such difficult social problems as pollution, learning how to better apply what we already know, and combating the bad effects of affluence (such as excessive food and lack of exercise). But, major efforts will have to be directed through channels of improved administration, coordination of paramedical personnel, rehabilitation, and better use of physician time.

Possibly, acute spinal cord injury represents an example where administration, organization, and coordination of efforts by medical specialists, nurses, hospitals, rehabilitation agencies, transportation, and local businesses is of particular importance in at-

tacking the medical, psychological, motivational, and vocational problems of this unfortunate group of patients. Although there is room for improvement in the technical medical care of these patients, the more difficult problems are the order in which procedures are performed, maintenance of nursing care at a high level of interest, transfer from hospital to hospital, vocational training problems, transportation, and the creation of jobs to fit the patient rather than vice versa.

The hospital has a number of well-defined functions. It is a place for the diagnosis and treatment of sick people, a place for the teaching of students, house staff and paramedical personnel, the "laboratory" of the physician, a center for research, and a place to die. The public hospital tends to accumulate patients with chronic diseases, multiple diseases, patients with multiple social problems, the poor, and the elderly. With the growing cost of hospitalization, it is becoming more and more important to analyze and measure what hospitals are trying to do and how well they accomplish these purposes. At present, hospitals are being analyzed in terms of the cost of each bed per day, bed utilization, number of days in the hospital for various disease entities, and death and autopsy rate. All of these measures are based on relatively clear-cut numbers which are accumulated and counted but do not really measure the effectiveness of the hospital. Before this can be measured, one must have clearly in mind what the hospital's purpose is and then one may be able to develop measurements to see if that purpose is being accomplished.

It has been the purpose of this and previous "Rehabilitation Notes" to take the point of view that a hospital should be primarily a rehabilitation unit and that it should be judged on the basis of how effectively it makes use of each patient's medical, psychological, social, and vocational resources and potential rather than on the exquisiteness of its diagnostic acumen, its therapeutic ability, its death or autopsy rate. These measures, of course, are basic and necessary and must be included in the overall evaluation, but are valuable only because they make the most of the patient's total potential.

The rehabilitation function of the general hospital includes the following elements:

1. Superior diagnosis, drug and diet therapy are the foundation for good rehabilitation. Too often the hospital's function seems to be limited to these methods. Too often a patient who has had superior diagnosis and treatment in the hospital negates the whole operation by failure in follow-up, development of preventable recurrences, or transfer to another hospital where the whole process is repeated. Follow-up is as essential as diagnosis and treatment.

2. The hospital also has a preventive function. Too often the hospital prefers to be the custodian



of disease rather than the guardian of the patient's total health.

3. Physical medicine, social service, and vocational rehabilitation may be the major needs of patients coming to the hospital and should receive appropriate support in terms of personnel and money to complete total rehabilitation.

4. Hospitals, physicians, medical schools, and paramedical personnel must be as interested in the social problems interfering with full attainment and maintenance of health, just as much as they are with availability of new diagnostic methods, new drugs, and new therapeutic modalities.

5. The general hospital must place patients in the most self-supporting position or in the cheapest facility *appropriate to their needs*, or both.

If a hospital is to accomplish these goals, it is necessary to set up criteria which measure rehabilitation accomplishment. Feinstein<sup>10</sup> has written perceptively on the formulation and reliability of criteria for judging health results. Little effort has been expended on evaluating the impact of hospitalization and the health-care system on the total harvest of the individual patient's living experience.

A second concern of recent "Rehabilitation Notes" has been on prognostic prediction of patient performance. We have used the Activities of Daily Living score to estimate in a semiquantitative manner how well predictions are realized.

### Summary

In the past, major medical advances have depended largely on the development of new methods of observation and new drugs. Attention has mainly been directed toward diseases. Success in therapeutic efforts has been judged in terms of whether the disease was cured, improved, unimproved, or whether the patient died. In the future, improvements in health care are going to depend more and more on improved application and integration of medical, psychological, social, and vocational resources of the individual patient. Success will be judged not merely in terms of disease, but to what

extent the patient is able to make full use of all his resources to function productively in his unique social system. "Style of life" of the patient will figure more and more prominently as a criteria in evaluation of health care. New criteria to define success will have to be developed. Methods of selection of patients who can be helped must be tried in order to separate those who can be helped from those who cannot.

This series of "Rehabilitation Notes" has attempted to develop certain criteria of physical performance and to see how well a single observer could prognosticate improvement in performance. It is the individual patient who is of unique interest to the clinician. The clinician is led to prognosticate because his brain is capable of special "noticing the unusual" and "isolating the pattern" which is, at present, not characteristic of the traditional statistical techniques. Once he has been so led to a formulated sort of guess, we can check on him actuarially.<sup>11</sup>

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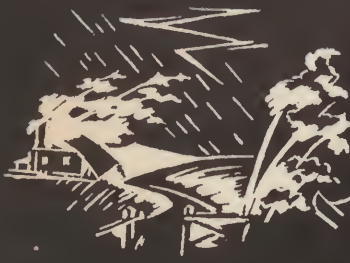


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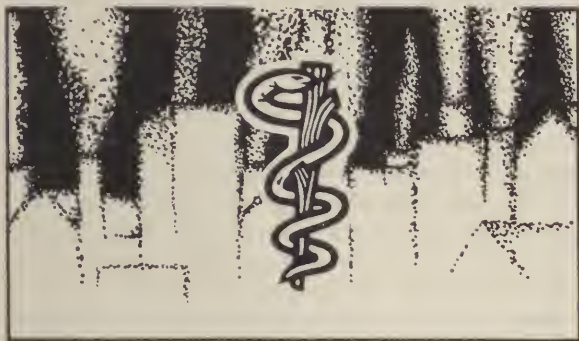
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## Alcoholism, Industry, and Public Health

Alcoholism affects society at all levels. Its consequences manifest as health, economic, psychological, and social problems. Industry is also affected by alcoholism, and the cost is high. Employee alcoholism programs initiated by industry have been successful in rehabilitating 60% of their problem drinkers. Public health should play a prominent role in combating alcoholism in the community and, specifically, in industry.

Alcoholism manifests its insidious effects at all levels of society. From a health standpoint, the incidence of and mortality rates from accidents, suicide, influenza, pneumonia, cirrhosis, acute myopathy, and acute renal failure are considerably higher in alcoholics than nonalcoholics.<sup>1</sup> An industrial employee survey comparing known or suspected drinkers with a control group showed a significantly higher incidence among drinkers of such disorders as hypertension, cirrhosis, peptic ulcers, asthma, diabetes, gout, neuritis, and cerebrovascular and heart disease.<sup>2</sup>

The alcoholics and their families often suffer serious mental and emotional consequences. Alcoholism has been called the family disease, for its emotional, economic, social, and often physical effects touch each member in such a family.<sup>3</sup> Costs for hospital care and welfare for alcoholics and their families in the United States exceed \$2 billion each year.<sup>4</sup> Children, in particular, are damaged by the lack of security, love, and warmth in such families and "neither the alcoholic father nor the alcoholic mother can play adequately the role of parent, so that there are gross failures of identification in the growing child—a condition which can warp all his future relationships".<sup>3</sup>

On our highways, alcoholics contribute disproportionately to the carnage which results from collisions. Over 50% of traffic fatalities are due to alcohol abuse.

A significant relationship also exists between criminality and alcoholism. One third of the total arrests in the United States for 1969 were related to the misuse of alcohol.<sup>4</sup>

In studies of alcoholism in industry, estimates of the prevalence of alcoholism among employees range from 1.5% to 10%, according to the type of industry. Among federal employees, an incidence of 5.9% was deemed appropriate.<sup>4</sup> Employed alcoholics have approximately 2½ times as many illnesses, injury-caused absences, and sick payments as their nonalcoholic co-workers.<sup>5</sup> In addition, indirect losses due to alcoholism in industry include "... bad decisions, discharges, dissension in work groups, early retirements, garnishments, lost sales, lowered worker efficiency and morale, overtime payments necessitated by absent workers, safety hazards and unfavorable public relations in the community".<sup>4</sup>

Considering the cost of alcohol abuse to industry—conservatively estimated at 25% of the annual salaries of problem-drinking employees—it is understandable that many companies have established alcoholism programs. Surprisingly and dramatically, these programs reported higher recovery rates than hospitals and clinics, approximately 60%, with striking reductions in absenteeism, discharge rates, and increases in productivity.<sup>6</sup>

As in every disease, early detection and proper motivation of the patient are crucial to the treatment process. With alcoholics, self-diagnosis is usu-



ally necessary before they will initiate or accept therapeutic procedures. "Early" alcoholics often deny having a drinking problem and use a variety of defenses to keep from admitting to themselves and others that their drinking patterns have become pathological. It is generally recognized that alcoholics will seek help only when they "hit bottom". Only when pain, frustration, failure, fear, or sheer desperation lead the alcoholics to confront the results of their drinking, and only when they realize they must consider alternatives to their self-defeating, self-destructive behavior will they accept help. The sooner that this receptivity occurs in alcoholics, the more hopeful the prognosis. It has been found that by constructive coercion, crises may be precipitated in the lives of alcoholics which may lead to their embarking on rehabilitative programs before irreparable physical, psychological, and social damage have been done. In this regard, employers play a crucial role.

"An alcoholic's job . . . is [often] the last great bulwark of his defense against admitting his illness; the threat of its loss can often produce the inward crisis that is required before he will submit to treatment. Well-conceived company programs, moreover, can speed up the precipitation of such a crisis, in the process rescuing men from unnecessarily long suffering at a cost to the company that is far less than the amount it is already losing through poor productivity, absenteeism, severance or retirement payments."<sup>1</sup>

Ordinarily, industry is not willing to become involved directly in the treatment of alcoholics; it has neither the staff, expertise, nor resources for such service. In addition, the cost of an employee alcoholism program that provides referral without treatment is considerably less expensive (about \$5 a year for each employee). The treatment of alcoholics traditionally has been a community responsibility wherein public health may play a vital role.

In liaison with industry, public health can make available trained and competent treatment personnel and provide clinical services directly to employed alcoholics and their families. In conjunction with such agencies as AA and BACA, public health may facilitate and encourage individuals, community agencies, voluntary groups, general hospitals, and others to offer programs and services to problem drinkers and their dependents.

Public health is uniquely prepared to assume the responsibility for coordinating programs for those suffering from alcohol abuse. It can be the "nerve center" into which employee alcoholism programs may be "plugged" for contact with a network of community services. Like no other agency or organization, public health has access to, or is assiduously involved in many alcoholism-related activities. From this vantage point, health authorities

may assume a key role in program planning and implementation.

The elements of employee alcoholism programs include establishing policies and procedures for handling drinking employees, educating company personnel about alcoholism and company alcoholism policies, training supervisors in their key role, and providing channels for referral and treatment. Public health can assist in all phases of such programs and should take an active and aggressive role in encouraging industry to develop these services.

Business and industry achieve exceptionally high recovery rates with problem drinkers. "The exceptionally high recovery rates achieved in business and industry . . . can be explained in part by motivation. For the employer, the desire to retain a valued employee, and to reduce excessive costs; for the employee, the goal is to keep his job and to arrest a serious illness which will get progressively worse unless he gets qualified help. Firm corrective disciplinary action, applied with the understanding that alcoholism may be the underlying cause of poor performance, will often save a valuable employee. It can also be the means of helping him to save his own life."<sup>6</sup>

Considering the enormity and destructive consequences of alcoholism, public health must take an active role in combating this serious health problem. Because industry can play a most significant role in helping to rehabilitate alcoholics through employee programs, the health department should initiate informational and educational procedures to acquaint employers with the cost, both human and economic, of alcoholism to their organizations. The advantages of adopting policies and procedures for dealing with alcoholism in industry should be promulgated.

The health department can offer consultation to company executives who wish to begin employee alcoholism programs. In addition, health officials may provide training to supervisors and other key personnel who have the responsibility for implementing the programs.

Seminars, lectures, audiovisual aids, and other materials may be employed to disseminate information concerning alcohol abuse and alcoholism to employees. Many problem drinkers who are exposed to such education seek help outside the company or voluntarily present themselves to designated personnel for referral and treatment.

In Baltimore County, there are nearly 23,500 alcoholics; of these, approximately 15,000 are employed. "The National Council on Alcoholism has estimated that it costs employers an amount equivalent to about 25% of the average annual pay of each alcoholic employee."<sup>4</sup> On the basis of estimates from other sources, the NCA estimate of 25% appears to be conservative. The median income for



a Baltimore County employee is approximately \$8,000. Thus, alcoholic employees cost industry in Baltimore County about \$30 million. We cannot begin to guess the cost in human suffering, misery, and tragedy.

Reiterating, approximately 60% of those employees who participate in treatment as the result of industrial alcoholism programs are rehabilitated. In Baltimore County, if all employers implemented such programs, we could expect that 9,000 alcoholics would be so affected. We could also expect reductions in hospital admissions, welfare payments, traffic collisions, and physical, mental, and emotional suffering.

Despite the success of employee alcoholism programs, many employers remain ignorant of the effects of their alcoholic employees, resist admitting that there are alcoholics in their organizations, or refuse to consistently maintain the strict policies necessary to put "teeth" into the alcoholism programs. Supervisors often hide or protect their problem drinking personnel in misguided acts of "kindness" and thereby delay the patient's self-confrontation and potential motivation for treatment.

Health departments must aggressively educate the

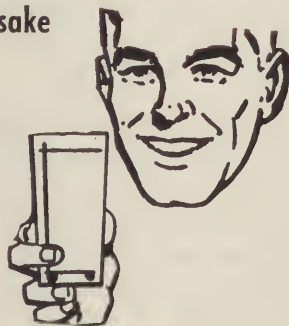
community to the effects of alcoholism and the key role industry may fulfill in combating the multifaceted alcohol-related problems, and provide training, consultation, and direct clinical services to alcoholics, their families, and agencies, businesses, and industry. No other organization has the sufficient personnel, vantage point, or expertise to assume the leadership and coordination of efforts necessary to effectively reduce the serious health problem which results from alcohol abuse.

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With the steady improvement in the therapy of cancer, and consequent increase in the number of 5-year survivals, our programs reflect increasing concern with the future of the cancer patient—with the *quality* of his survival.

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by the Society, the International Association of Laryngectomees, through its local IAL clubs, provides such services as individual and group speech therapy, psychological counseling, visits to new patients, safety training, public education and social activities.

Our rehabilitation programs not only give heart and help to patients but provide the physician with vital aids necessary to improve the *quality* of survival.

**American Cancer Society** 







(fluorouracil)  
cream/solution

In the treatment of  
solar/actinic keratoses—

An alternative  
to cold, fire and steel

2/23/68

Before treatment with 5% 5-FU cream.  
Patient R. G., 78 years old, shows  
extensive skin changes due to weathering  
and severe solar/actinic keratoses.

3/26/68

Following one month of therapy. Intense  
erythematous reaction is seen at sites of  
keratoses. Normal skin has not reacted.  
Some areas which had reacted initially  
have undergone healing despite continued  
topical application of 5% 5-FU.

6/11/68

Ten weeks after discontinuance of  
therapy. All areas have healed completely.  
Residual mild erythema remains in some  
areas. This patient also had seborrheic  
keratoses which, as expected, have not  
reacted. There is no evidence of residual  
lesions or recurrences.







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## An alternative to conventional therapy

Efudex (fluorouracil) offers the physician a topical alternative to cryosurgery, electrodesiccation and cold-knife surgery in the treatment of solar/actinic keratoses. It is effective, comparatively inexpensive and especially well suited for treatment of these multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.\*

## Highly effective

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 72 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When new lesions appeared, repeated courses of Efudex therapy proved effective.\*

## Predictable therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three months before gradually receding. Since this response is so predictable, lesions which do not respond should be biopsied.

## Two strengths—two dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings

and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



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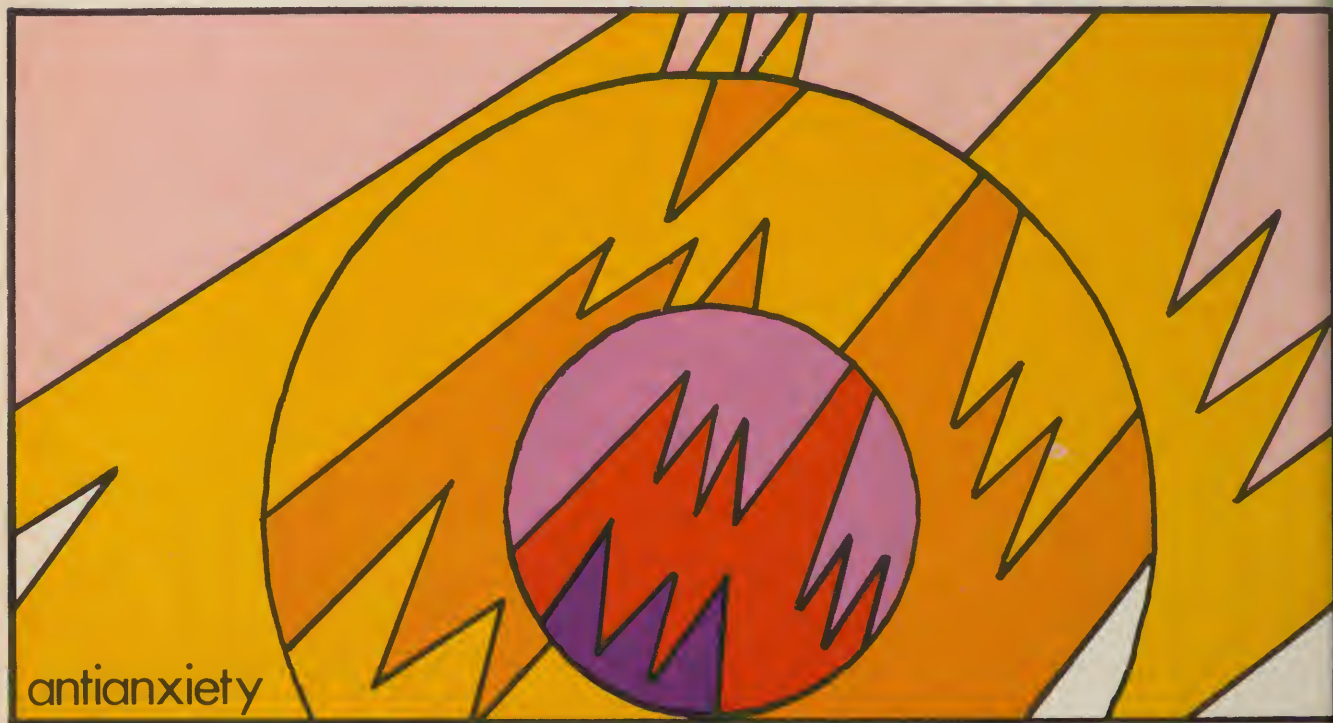
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# anxiety: a time bomb

Unless "defused," anxiety may build up to an intensity that can overwhelm the patient's inner defenses. Also, in one weakened by chronic illness or surgery, excessive anxiety may provoke or aggravate symptoms and interfere with recovery.

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**Before prescribing, please consult complete product information, a summary of which follows:**

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**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating ma-

chinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychotic patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impend-

ing depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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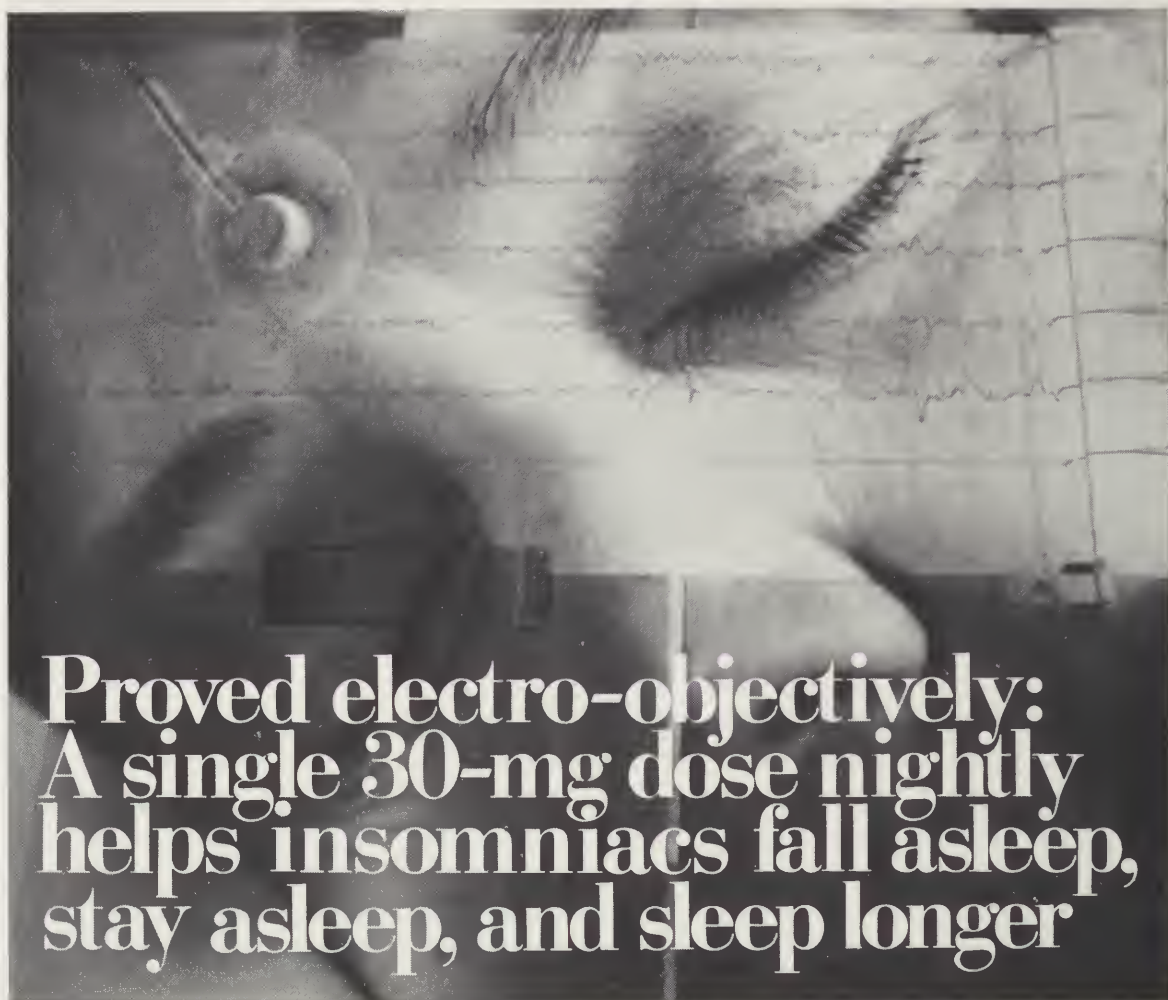
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# Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.<sup>1,2,3</sup>

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,<sup>1</sup> Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

---

## Confirmed clinically

---

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.



In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

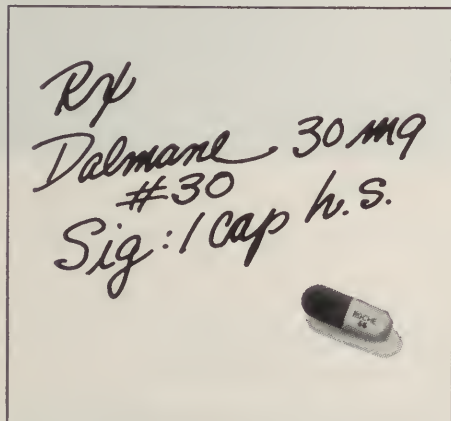
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### Dalmane (flurazepam HCl) is generally well tolerated

---

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.<sup>3</sup> Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

**References:** 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane**<sup>®</sup>  
(flurazepam hydrochloride)

### Before prescribing, please consult Complete Product Information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

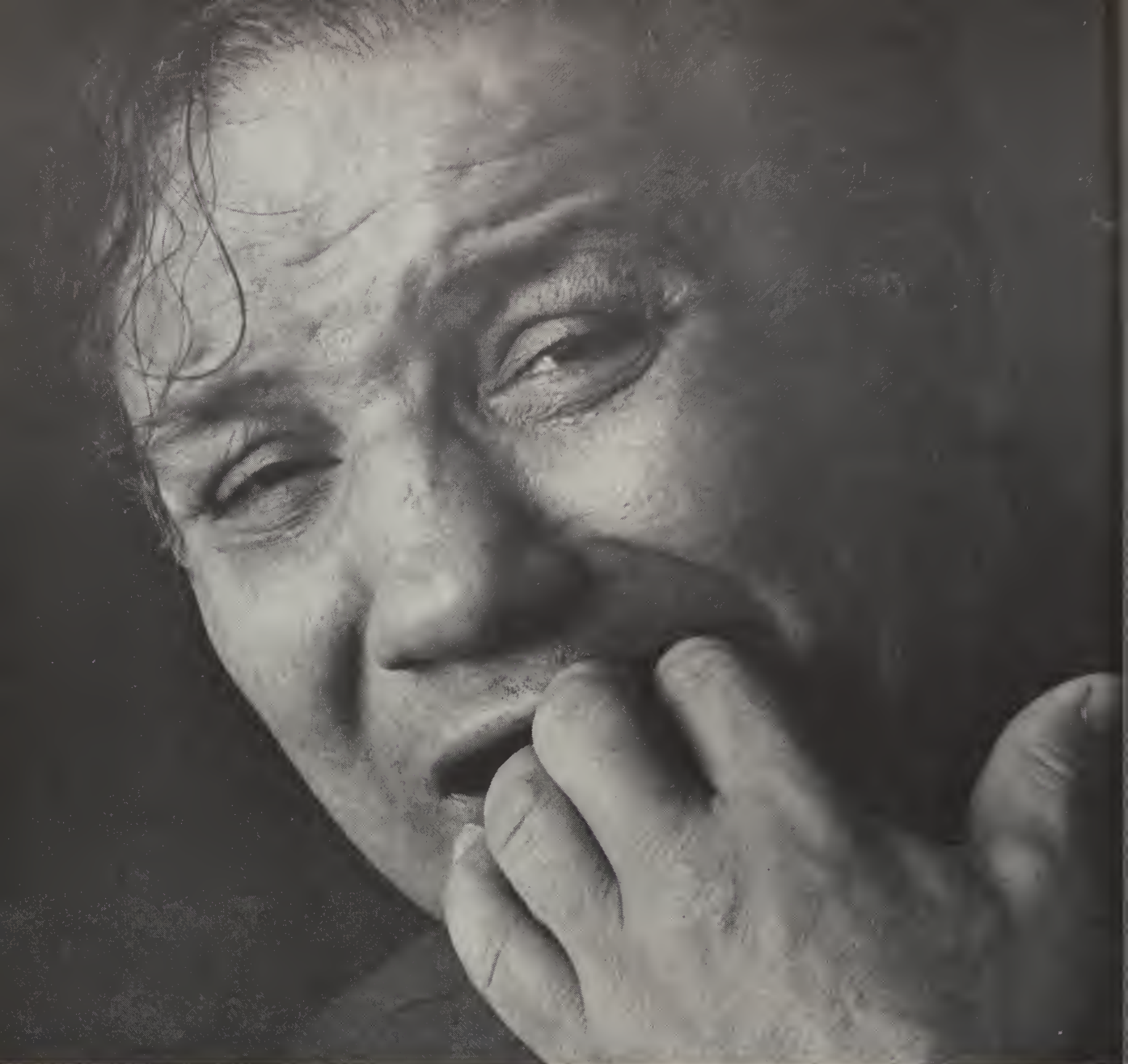
**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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**AMERICAN ASSOCIATION OF OPHTHALMOLOGY/NEW JERSEY EDUCATION ASSOCIATION**

Conference on Learning Disabilities: 2 PM, Borton Hall, Dennis Hotel, Atlantic City, New Jersey. A multidisciplinary panel will discuss the various aspects of dyslexia and learning disabilities as they concern the educator, pediatrician, family physician, ophthalmologist, neurologist, otologist, psychiatrist, and pediatric psychologist. There is no registration fee. For further information, write: American Association of Ophthalmology, 1100 7th St., NW, Washington, D. C. 20036.

**JUNE 20-24, 1971**

**AMERICAN MEDICAL ASSOCIATION**

120th Annual Convention: Atlantic City Convention Hall, Atlantic City, New Jersey. The program will include lectures, panel discussions, and symposia, scientific and industrial exhibits, daily showings of new medical motion pictures and demonstrations of diagnostic and treatment techniques. Contact: American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610.

**JUNE 25, 1971**

**DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF VIRGINIA**

Continuing Education Program—The Multiproblem Family: Boars Head Inn, Charlottesville, Virginia. For further information, write: W. D. Buxton, MD, Assistant Professor of Psychiatry, Box 190, University of Virginia Hospital, Charlottesville, Virginia 22901.

**JUNE 28-JULY 2, 1971**

**NEW ENGLAND STATES REGION, EASTERN CANADIAN REGION, NEW YORK STATE SURGICAL DIVISION OF THE INTERNATIONAL COLLEGE OF SURGEONS**

13th Annual Midsummer Meeting—What's New in Medicine: Mount Washington Hotel, Bretton Woods, New Hampshire. The five-day session will emphasize the latest developments in each field of surgery as they apply to the practicing physician and their use in the hospital setting. Write: Salvatore R. Traina, MD, 155 High Street, Medford, Mass. 02155.

**JULY 7-15, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS**

Postgraduate Course in Venereal Disease Control: Atlanta, Georgia. Topics include epidemiology, eradication, behavioral science aspects, clinical syphilis, clinical gonorrhea, granuloma inguinale, and chancroid. There will be two sessions: July 7-10 and 12-15. Contact: James C. Lucas, MD, Assistant Chief, Venereal Disease Branch, State and Community Services Division, Center for Disease Control, Atlanta, Georgia 30333.

**JULY 22-23, 1971**

**COLBY COLLEGE**

Second Annual Seminar in General Surgery: Colby College, Waterville, Maine. The seminar will discuss areas of management of trauma, vascular disease, breast disease, and problems of the biliary tract. For further information, write: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.



**JULY 26-29, 1971**

**AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Recent Advances in Rheumatic Diseases: Stanley Hotel, Estes Park, Colorado. Co-sponsor is the University of Colorado Medical Center in Denver. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**JULY 26-AUGUST 5, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Symposium on Research in Deoxyribonucleic Acid (DNA) Replication: Aspen, Colorado. Contact: School of Medicine, Washington University, 660 South Euclid Avenue, St. Louis, Missouri 63110.

**AUGUST 29-30, 1971**

**AMERICAN MEDICAL ASSOCIATION**

31st Annual Congress on Occupational Health: Jackson Lake Lodge, Grand Teton National Park, Wyoming. Write: Louis R. Skiera, Assistant Director, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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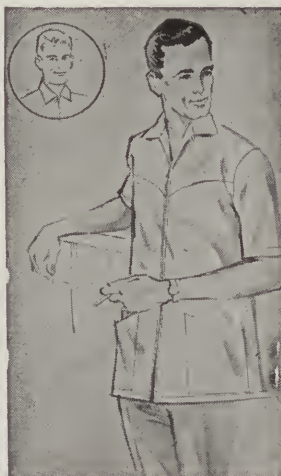
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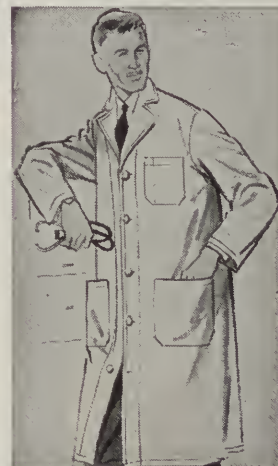


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# executive director's newsletter

June 1971

## CORRECTION

An INCORRECT statement appeared in May regarding validation stamps for vaccination forms. It should read: Validation for foreign travel of certificates of vaccination (smallpox or cholera) is available at all local health offices, by mail or in person. Any physician performing 300 or more such immunizations may apply to the State Health Dept. for his own stamp.

## ANNUAL MEETING

In the business sessions of the House, action indicated was taken on the following resolutions:

1A/71 -- Resolved, That the Council of the Medical and Chirurgical Faculty of the State of Maryland be directed to seek out and employ a qualified negotiator, in whose charge would be placed the responsibility for dealing with third party payment mechanisms under the policy direction of an appropriate committee; and be it further

Resolved, That the duties and responsibilities of such an individual include other related socioeconomic matters deemed appropriate by the Council. (Referred to the Policy and Planning Committee)

2A/71 -- Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urges the formation of home health care services programs for the residents of Maryland; and

Resolved, That since many Blue Cross plans throughout the country now offer home care services coverage to their subscribers, the Medical and Chirurgical Faculty of the State of Maryland request that Maryland Hospital Services, Inc., work with the medical and related professions to formulate plans for home care services for its subscribers; and

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland take any necessary action to find methods for initiating and financing such a program under Medicaid and Medicare. (Adopted)

3A/71 -- Resolved, That the House of Delegates communicate its immediate concern to the Dean of the University of Maryland School



ANNUAL  
MEETING  
(cont'd)

of Medicine and the Johns Hopkins University and its School of Medicine, to establish a

separate department of Family Practice at these Schools of Medicine, on equal par with the other major departments, in place of the present Division of Family Medicine at the University of Maryland School of Medicine which is under the Department of Medicine; and as a new department at the Johns Hopkins University School of Medicine and that these separate departments be funded in a realistic manner in relation to their needs. (Adopted)

NEW -  
DANGEROUS  
DRUG  
REGISTRATIONS

There is considerable confusion over the new regulations implementing the Controlled Substances Act of 1970. Physicians are now required to have registrations to prescribe or dispense all drugs that come within the provisions of this act.

While the deadline for registration has been extended to July 29, 1971, physicians who have not already applied for the new number should do so promptly. If no application for such a number has been received or if you have any questions regarding this new procedure contact the Baltimore Regional Office, Telephone (301) 962-2224.

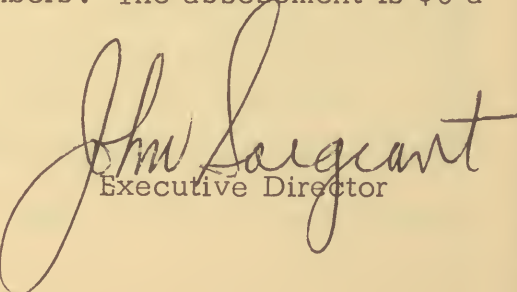
In general, physicians are required to hold a number to prescribe all five classes of the drugs that are involved.

SEMIANNUAL  
SESSION

An Eastern Airlines 747 has been chartered for the Faculty's Semiannual Session in Puerto Rico from September 12-14. Complete details may be obtained by calling the Faculty Office or Mrs. Beverly Wolins at the Travel Guide Agency, Telephone Number (301) 727-1696.

DUES  
AND  
ASSESSMENT  
INCREASE  
VOTED

A dues increase of \$20 and an annual assessment for the purpose of medical education were approved by the House of Delegates, effective with the 1972 dues year. Both of these items are applicable only to active Faculty members. The assessment is \$5 a year.

  
Executive Director



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ARTHUR E. COCCO, MD  
Journal Representative

## Baltimore City Medical Society

The Board of Directors of the Baltimore City Medical Society met on April 13 in the Medical and Chirurgical Faculty building. The minutes of the previous meeting were approved and consideration was given to waiving the dues of a member who had been ill during the past year. No decision was made in this regard, pending a recommendation of the treating physician.

Richard London, MD, Chairman of the Professional Relations Committee, presented a request that the committee be enlarged from three to five members. This committee considers all complaints received against members of the society and it was felt that two additional members would alleviate the burden carried by the present membership. It was agreed that this would be carefully considered and additional members appointed if possible.

In response to a request from Med-Chi that each component submit a name to be placed on a list from which the Governor will choose a member of the Maryland Commission on Medical Discipline, the board suggested that the name of John N. Classen, MD, be proposed.

The board approved the following recommendation made by the Policy and Planning Committee:

"The President should always be available to representatives of the news media for appropriate comment on medical or other matters affecting the Society. A public relations committee should provide necessary support, and assist by issuing news releases at regular intervals on matters of interest to the Society."

John De Hoff, MD, Chairman of the Policy and Planning Committee, explained that this was not intended to be a criticism of the present administration but an attempt to formulate a policy by which the present administration and future administrations could operate. Presently, there is no officially designated spokesman for the society and it was felt that the president should be designated as such.

In response to a letter from the Archdiocese of Baltimore, brought to the board's attention by

Robert Farber, MD, concerning the treatment of physicians to foster children under the care of the Archdiocese, the board agreed that treatment should be provided for these children and that the state should also be urged to pay the usual and customary fee for the office visits.

Elliott Fishel, MD, the society's representative on the Maryland Health Maintenance Committee and the First Maryland Health Care Corporation, gave a report on the activities of these groups. The Maryland Health Maintenance Corporation consists of representatives from many lay organizations, several hospitals, the Monumental City Medical Society, the City and State Health Departments, Garwin Medical group, the Baltimore City Medical Society, and other interested parties. The committee hopes to obtain planning funds from HEW for a program which will eventually provide prepaid medical care to union members, members of the general public, and Medicare and Medicaid recipients. It is hoped that the program will encompass the entire Baltimore metropolitan area. The committee will not provide medical care, but will act as an administrative agent and coordinator.

The First Maryland Health Care Corporation is planned to service the northwest section of Baltimore city and involves the Baltimore city and Monumental City medical societies, and Garwin, Sinai, Lutheran, and Bon Secours hospitals. Funds have been received from Blue Cross and other sources to begin a prepaid care program at Bon Secours Hospital and it is hoped that OEO will provide additional funds.

It was pointed out that these groups sometimes fail to consider that there is no formula in the programs to provide more physicians to supply the increased services which these programs will demand. In addition, if hospitals pledge to supply a number of patient beds to these programs without increasing the present number of beds available, it will lessen the available facilities to private practitioners.

It was voted to send a representative to the




National Conference on Peer Review to be held in Chicago on May 21 and 22.

A question was raised as to whether there is an approved list of collection agencies to which physicians might refer when choosing the agency to use. This will be investigated and a report provided the board.

A letter concerning the problem of open staff privileges at hospitals from M. B. Levin, MD, was presented to the board. It was agreed that since the Medical Care Committee is presently discussing this problem, the letter would be referred to that group for consideration.

Dr. Wagley pointed out that the Baltimore City Medical Society must increase its activities in order to become an effective force in the city and that to do this might require the employment of a full-time executive director. Dr. London was requested to investigate the cost of employing such a person and to make an estimate as to how much the dues of the society would have to be increased to provide increased services.


There being no further business, the meeting was adjourned at 6:15 PM.



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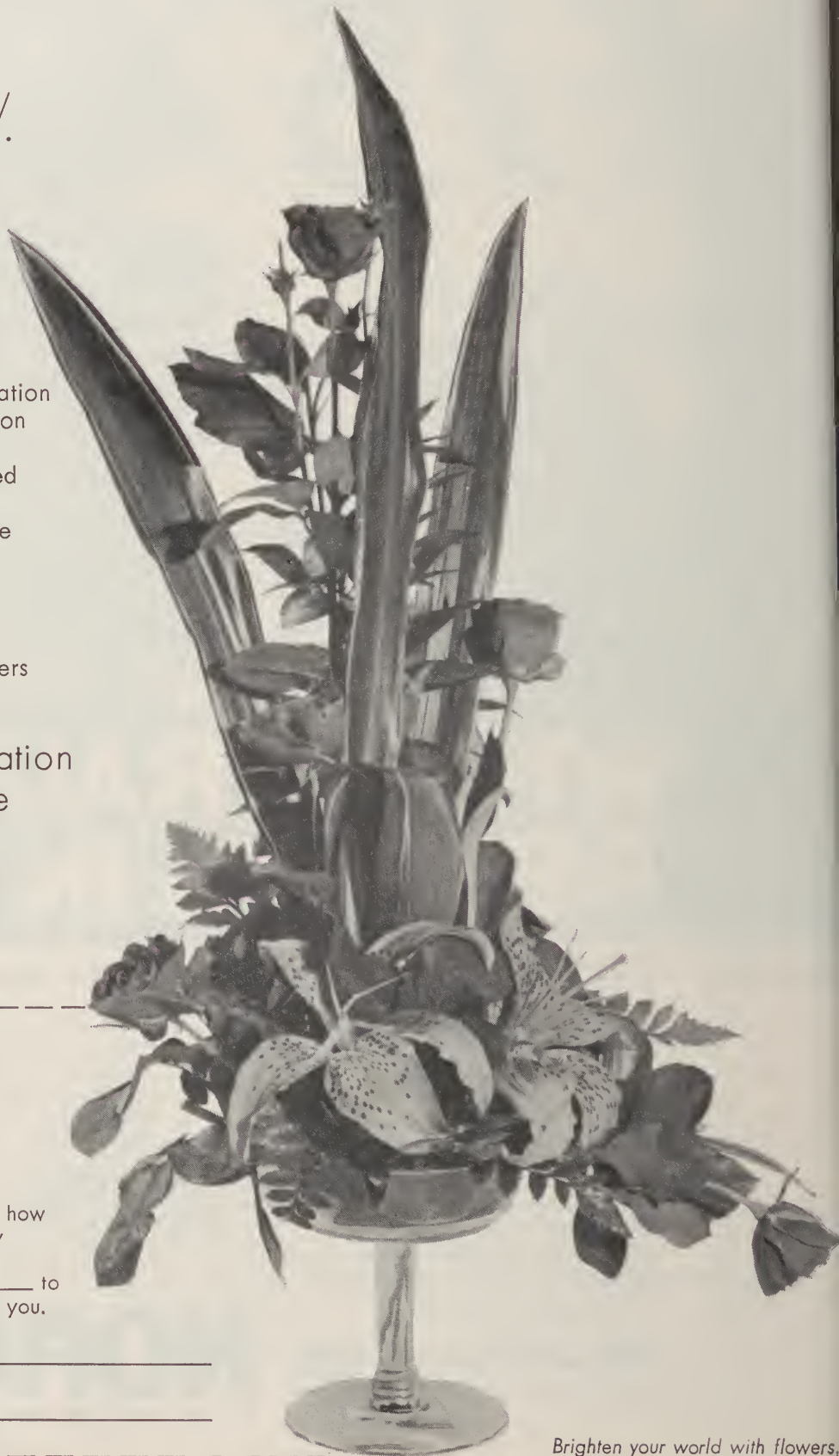
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Amend, William J. C., Jr., MD, 2682-H Buckner Ave., Ft. Meade, Md. 20755  
Andrake, William, MD, 4242 East-West Highway, Apt. 1112, Chevy Chase, Md. 20015  
Arnold, Charles J. E., MD, 116B Cross Keys Rd., Baltimore, Md. 21210  
Ashman, Ruth S., MD, 6612 Bonnie Ridge Dr., Apt. 102, Baltimore, Md. 21209  
Aybar, Olimpia L., MD, 3508 Stoneybrook Road, Randallstown, Md. 21133

### B

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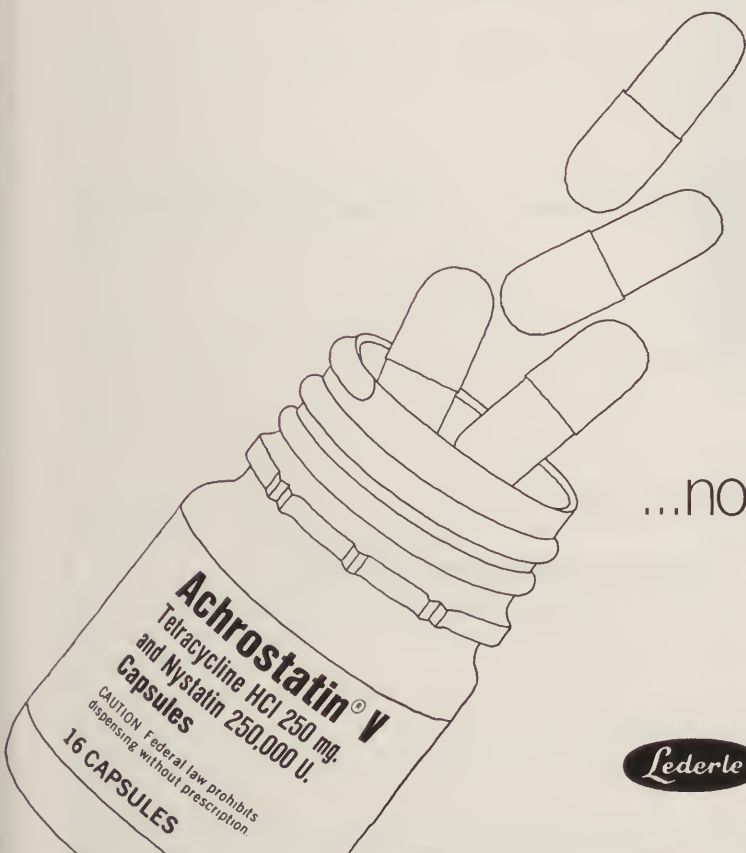
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MRS. ROBERT W. GARIS, EDITOR

## woman's auxiliary

# Mrs. Yow Gives President's Report

As President, it has been my privilege to attend to the affairs of your Auxiliary for the past year. I have also been privileged to have been included on the Med-Chi Program and Planning Committee meetings. Mrs. Leonard Warres has served very capably as a liaison member to the Med-Chi Public Relations Committee. Communication is vital to both you and the Auxiliary in order to accomplish worthwhile goals.

Four state board meetings were held in addition to the Semiannual Meeting and the present convention. The highlights of the Semiannual Meeting were the Hobby Corner and the entertainment that hopefully brightened and lightened the meeting for you. We had fun planning the entertainment and hope that you enjoyed it.

As an ad-hoc member, I attended eight Program and Planning Committee meetings. At the request of the Chairman, I made special trips to Ocean City and Hershey, Pennsylvania in connection with the Semiannual Meeting held last September.

One of my duties as President is to represent the Auxiliary at the conventions of surrounding states. My travels carried me to Delaware, New Jersey, New York, Pennsylvania, West Virginia, and the Eastern Shore of Virginia. Due to conflicting dates, I was not able to accept invitations to attend the meetings of the District of Columbia or the State of Virginia. Official visits were made to each of the 11 component auxiliaries of the state of Maryland.

Please accept my gratitude on behalf of the Auxiliary for your continued financial support of \$1,000. Without your support and the valued assistance of "our Miss Wynde" and the rest of the staff at Med-Chi, we could never survive. I also want to thank you for joining us in cosponsoring and cosigning a charter for the Health Careers Club of Maryland. There were 39 high school clubs with a total of 750 students affiliated with the state this year. It behooves all of us to encourage more young people



Mrs. Raymond M. Yow

to enter the medical profession. The Health Careers Club is one of many ways to disseminate information on medical careers to interested students of junior as well as senior high school age.

Rather than a state AMA-ERF project (Laurel Day at the Races the past two years), we encouraged the individual auxiliaries to develop their own project in their own areas. We did continue the Christmas card sales as usual and also sold AMA-ERF stationery supplies given to us by the national headquarters of AMA-ERF in Chicago.

As of March 28, the total raised by the Auxiliary was \$3,079.03. More donations are coming in and will make the total at least equal to last year's total



of \$4,547.40. These figures do not include the physicians' contributions through Med-Chi.

Some of our members participated in the workshops leading to the White House Conference on Children and Youth but were not participants of the conference held in Washington. Mrs. Jonathan Williams, National Auxiliary Chairman of the Mental Health Committee, attended the conference from Maryland.

Med-Chi and the State Department of Health approved material concerning immunization that the Auxiliary Community Health Chairman used to publicize Community Health Week, October 18-24, 1970, on the radio and through other news media.

Doctor's Day (March 30) was observed by every component auxiliary. The various ways used to honor our husbands included carnations in offices or hospitals, or both, luncheons, cocktail-dinner parties, and dinner-dances.

With the help of the Med-Chi staff, our enthusiastic and energetic International Health Chairman planned and carried through an ambitious project to raise money for the S.S. HOPE which is listing Baltimore as the home port this year. Arrangements were made for a private tour of the ship which was followed by a cocktail buffet dinner held at Martin's West. Some 200 physicians and their wives were present at the evening function and enjoyed the open bar, music, special decorations, food, style-show, and raffle. The date, January 2, was the only one available to us for touring the ship. This project was a jointly sponsored affair with Med-Chi. The date was not particularly good (weather and otherwise) and we were disappointed with the poor attendance. Such a worthwhile project deserved support and I'm sorry more members of Med-Chi and the Auxiliary were not present. Despite the obstacles of poor weather and apathy, we did end up with net proceeds of over \$600 to forward to S.S. HOPE. The Auxiliary donated an infant croupette and some component auxiliaries gave miscellaneous items such as jonny coats, bandages, and bed linens.

One of our priority committees was legislation this year. Members of the committee (representa-

tives from each county) were invited to spend the date at the State House during the spring session. After our visit and luncheon, we were privileged to have Dr. Aris Allen, Delegate from Annapolis, speak to us on several pending bills in the legislature. A few of the component auxiliaries also made a trip to Annapolis part of their activities for the year.

We also focused our efforts on community service and encouraged individual members to serve where needed in their local areas. Service as defined included P.T.A., church, hospital, service agencies, as well as the diverse area of preventive medicine on a community level.

We continue to be concerned with membership. Our biggest stumbling block in retaining old members as well as attracting new members is the disinterest and apathy of the physicians. Without encouragement from the physicians on behalf of the cause of their Auxiliary, one cannot expect much enthusiasm to be a member from the physician's wife. My experience this year has suggested to me that in many instances the physician has actively discouraged his wife from participating in Auxiliary affairs, and this can only be interpreted as a lack of understanding as to the aim and purpose of the Auxiliary. Needless to say, this aspect of my term has been somewhat disheartening to me as it doubtless has to those presidents I've followed.

Hopefully, if we can continue to work, we will eventually reach each physician and his wife and will achieve our full potential as an auxiliary.

Allow me to paraphrase a statement made by Mrs. R. C. L. Robertson, National President of the Auxiliary, to the American Medical Association: "Every physician should realize that the medical Auxiliary is actually connected to his livelihood. This is the organization most closely related to the physician's consuming interest—the good health of the people." This clearly defines the most important reason for a medical Auxiliary.

**Mrs. Raymond M. Yow**

*Presented to the House of Delegates of the Medical and Chirurgical Faculty on Friday, May 14, 1971.*

## Mrs. Reiter Gives President's Inaugural Address

Officers, Delegates, Members, and Guests:

In accepting this honor which you have bestowed upon me it will be my pleasure, as well as my duty, to fulfill the obligations attendant upon this office to the utmost of my ability. It will be no easy task to follow in the energetic footsteps of our immediate past-president, who accomplished an awesome amount of work for the Auxiliary, but you have my

pledge to perform faithfully all the duties incumbent upon the office.

Our National Society is stressing the work of three committees in particular: Membership, AMA-ERF, and Health Careers. These are areas in which our Auxiliary can give substantial support.

Next year, 1972, will be the 50th anniversary of



the founding of the Woman's Auxiliary to the American Medical Association, Inc., and the Auxiliary is striving to attain a membership of 100,000 physicians' wives in honor of a half a century of work in volunteer health services. We in Maryland are planning a vigorous membership campaign to aid in achieving this goal.

Maryland has always strongly supported AMA-ERF and will continue to do so. We recognize the need for educating a greater number of physicians to operate the vastly increased health services. You know, they say it is love that makes the world go round, but it is science that makes it go forward!

And finally, health careers is a project dedicated to educating young people to the fact that health care is not only accomplished through physicians and nurses, but through 240 different allied health professions. Part of our work is in recruiting people for these health professions and a very important part is raising money for scholarships and loans for health careers. Maryland need not take a back seat to any state auxiliary in this effort. Under past presidents there have been fine programs to steer high school students into the field of health services and much money has been raised to support loans and scholarships. I promise to continue this and, where possible, enlarge these programs, knowing that our ever-growing population will need ever-increasing numbers of health personnel.

In planning our programs we must be willing to face change. We must not shut our minds to what is taking place in today's society, including the practice of medicine. We must learn to "roll with the punches." Our young people have a vastly different concept of the conveying of health services than did graduates of even ten years ago. So, let us adopt the best new ideas and try to moderate the most radical.

Our Auxiliary pledge urges us to sustain the high ideals of the medical profession. How can we, as physicians' wives, do this? On a personal level, we can accomplish this by the help and encouragement we give our husbands, and as auxiliaries, by our community involvement in projects bringing better health standards to all ages and classes. Many of you are doing a tremendous job in your hospital auxiliaries. But there are many areas the hospitals do not reach and this is where our work begins. Malnutrition, ugly living conditions, infant mortality, problems of the aging, the need for more mental health day care centers, the frightening increase in drug users among our youth: The list is almost overwhelming. Let us, however, not be drowned by these woes, but accept them as a challenge and go into the future fighting for a better world.

**Mrs. Robert A. Reiter**

*Presented at the Annual Luncheon, during the Annual Meeting of the Woman's Auxiliary of the Medical and Chirurgical Faculty, Thursday, May 13, 1971.*



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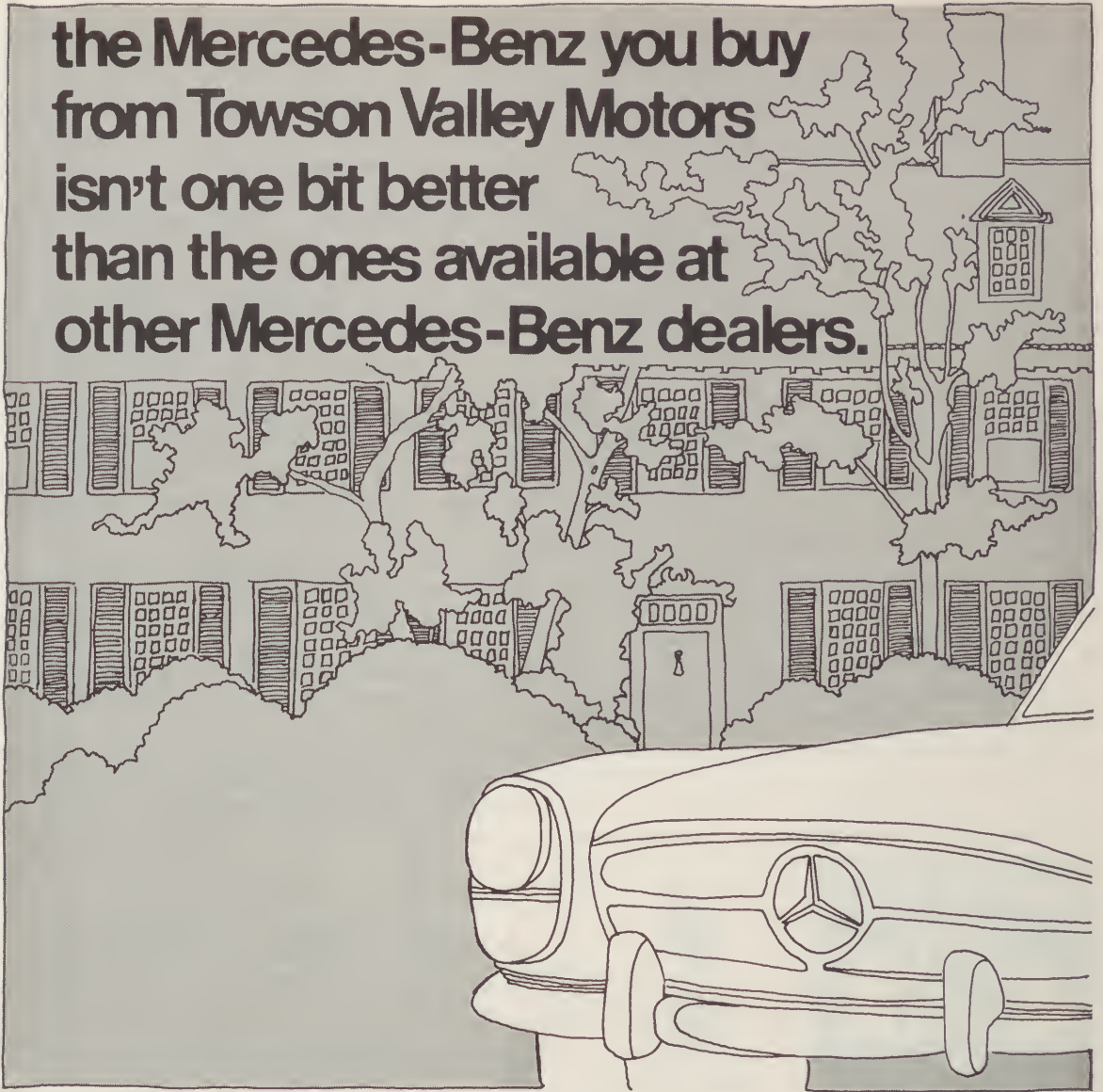
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**To transfer from sulfonylurea therapy to DBI-TD alone:** The first week, withdraw sulfonylurea; start with DBI-TD as indicated in the chart.

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**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions:** **Starvation Ketosis**, which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. **DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS. Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones

in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331. Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.





# THE MONTH IN WASHINGTON

**New government regulations for medicaid include a requirement that the physician certify a patient's continuing need for in-patient care on or before the 12th day of hospitalization and again no later than the 18th day.**

Other final regulations issued by the Department of Health, Education and Welfare give the Internal Revenue Service more power to police income earned under the medicaid program. States must file annual information returns showing aggregate amounts paid to providers of services identified by name, address, and social security number or employer number.

HEW officials said the new regulations on hospitalization certification are expected to reduce medicaid expenditures by cutting down on the time spent by patients in hospitals.

"Experience with medicare has shown that requiring certification or recertification by physicians reduces hospital stays significantly," John Twiname, administrator of HEW's Social and Rehabilitation Service, said. "Applying this requirement to medicaid can cut its costs without lowering the quality of care."

Inpatient hospital costs have been accounting for about 40% of total medicaid expenditures, or about \$1.9 billion in the fiscal year 1970.

\* \* \*

**The speaker of the American Medical Association's House of Delegates has warned against exaggerated claims that national health insurance is the total answer to the nation's health-care problems.**

Testifying before the Senate Finance Committee, Russell B. Roth, MD, Erie, Pa., said the medical profession as represented by the AMA is "concerned by the over-promise which seems inherent in a wide variety of legislative proposals placing strong reliance on a restructuring" of the health-care delivery system in this country.

"We caution against the attractive but totally impractical notion that one legislative act can solve the problems (as to health care) of a profoundly troubled society," he said.

"We commend to you our specific proposal (Medicredit) for attacking financial barriers. We also solicit your support in ongoing efforts to augment manpower, to improve practice patterns, to apply effective measures to moderate and contain costs, to meet the challenges of the inner-city and the rural scene, and in general to meet the goal that no one shall be deprived of the best health care that is within our power to provide."

"Those of us who are in group practice, and there are over 40,000 of us, have our own concepts of its advantages to our

patients and to us," Dr. Roth said. "But few of us look upon group practice as a panacea. The notion has been advanced that the AMA opposes salaries for physicians and champions direct fee-for-service alone. This would come as news to our large number of member physicians who derive their income in whole or in part from salary. It is a false premise. Upon it is based the allegation that fee-for-service favors over-treatment and prepayment does not. One might as logically assert that prepayment favors under-treatment. Actually, a good and conscientious physician responds with consistency to the needs of his patients as he sees them.

"One hears over and over the statistical studies to show reduced utilization rates under prepayment. But less prominence is given to other studies such as that by the Russell Sage Foundation which concluded that nearly half of all members of the Health Insurance Plan of Greater New York and also of the Labor-Health Institute go outside of the plan for some medical service. It is not our aim to downgrade prepaid practice. Many physicians, as well as many patients, like it. Under the Kaiser plan, only some 15% of beneficiaries who have opted into prepayment coverage opt out of it later on. But mark you, they do have an option.



"It is implicit in our defense of a pluralistic flexible system that prepaid group practice and such modifications of it as may be devised under the title of health maintenance organizations should have their opportunity to demonstrate their capacities to provide effective, efficient, and economical care. Any freeze into a single mold would deprive our nation of the benefits of competition and comparison. Here, legislative mandate can do more harm than good.

"In a somewhat similar vein of caution we would note that there is danger in expecting too much of professional services review or peer review. To attempt to legislate it into effective being may be a frustrating experience. The frustration stems from the fact that when the question concerns the appropriateness of technical, medical care and the equity of charges for it, only another physician can pass the judgment. This is a fact which is forcing upon physicians the obligation to evaluate the practices of their colleagues. Large segments of the medical profession take substantial pride in their accomplishments in this respect.

"In applying the principles of peer review the reviewing group seeks to uphold quality, to promote efficiency, and to eliminate departures from accepted practices and equitable charges. By and large, practicing physicians accept the necessity for checks and balances in the paying out of public funds and private funds as well. On the other hand, they have no appetite for the job to be done by nonmedical persons or agencies ill-equipped to judge. This is why they are willing to redouble their efforts within their professional organizations to do the job well. We know of no successful efforts to legislate ethics or morals, which must be at the heart of any system of

competent, conscientious delivery of medical care. On the other hand, we know of no profession which has shown a better motivation or performance through its collective professional organizations to rule out abuses and lack of competence. It is of paramount importance to support the progress which has been made, not to cast it aside.

"We would also caution against uncritical acceptance of the statement that it is somehow possible to legislate American medicine into a system of 'health care' as opposed to 'sickness' care. The great advances in adding to life expectancy have been achieved in world medicine by controlling epidemics and plagues, draining swamps, purifying water, and devising immunizations. Smaller gains have been made in individual physician-patient encounters, removing diseased organs, supporting failing hearts, controlling diabetes, and the like. Few gains, indeed, have been made or can be made through changing the role of the physician in respect to well patients. Not that there is any shortage in things to be done, especially in the realm of public education. Nutrition can be vastly improved, cigarette smoking can be curbed, drug addiction and alcoholism somehow must be abated, proper exercise may be promoted, accident prevention is essential, environmental deterioration must be reversed. But how many of these things can be done by the individual physician, besieged as he is by those who are or think they are already sick?

"The things that are to be done are the province of our public health organizations, voluntary health agencies, communications media, government, and our professional educational associations such as the AMA. All physicians practice some degree of preventive medicine.

Many could do more. But to believe that some sort of basic restructuring of medical practices could yield great dividends in this respect is wishful, impractical thinking."

\* \* \*

**The American Medical Association urged that the Food and Drug Administration modify a proposed new policy on the continuation of marketing combination drugs.**

In testimony before the House Health Subcommittee, John R. Kernodle, MD, Burglington, N.C., vice chairman of the AMA Board of Trustees, said:

"We recommend that all preparations judged by the Drug Efficacy Study as 'effective' and 'probably effective' should remain on the market; that all drugs judged 'ineffective' be removed from the market; and that the drugs categorized as 'possibly effective' be reviewed by clinically experienced consultants to the FDA, within a period of one year (instead of the allowed six-month period), to determine if further scientific evidence supports continued marketing."

"The drugs categorized as 'effective, but' have been resubmitted to the National Academy of Sciences-National Research Council panels and, accordingly, we recommend that no action should be taken with respect to this group until that review has been completed.

"Many of the mixtures categorized as 'ineffective as a fixed combination' are commonly prescribed and judged by physicians and patients as highly satisfactory. To summarily remove all such preparations would result in dismay and inconvenience for a large segment of the public. Therefore, we recommend that preparations designated as 'ineffective as a fixed combination' should be reevaluated by prac-



ticing physicians who are qualified as clinical specialists.

"We reaffirm our belief that continuing professional education through AMA-Drug Evaluations and scientific journals is the method of choice for improving prescribing practices of physicians, and that the physician should continue to have the fullest armamentarium of drugs for treatment of his patients.

Dr. Kernodle said the medical profession was concerned with the effect that the proposed new FDA policy would have on medical practice, if it was not modified.

"Many fixed dosage drug combinations which have been used by substantial numbers of physicians, without harmful or adverse reactions and with what qualified, expert clinicians judge to be beneficial effects, will be placed in jeopardy," he said. "We do not believe that patients should be denied effective therapy which is safe, convenient, and economical. Lest there be any misconception, I want to point out that the 'safety' of the drugs is not in issue, since the drugs were earlier determined by the FDA to be safe in order for them to be marketed."

In a letter to the hearing clerk of the Department of Health, Education and Welfare, Ernest B. Howard, MD, AMA executive vice-president, said:

"The medical profession is concerned with the effect the proposed statement would have on medical practice. Many fixed drug combinations which have been used by substantial numbers of physicians without harmful or adverse reactions and with what qualified, expert clinicians judge to be beneficial effects will be placed in jeopardy. We do not believe that patients should be denied effective therapy which is safe, convenient, and economical."

\* \* \*

**The American Medical Association supported legislation that**

**would extend the federal programs of assistance for training of physicians, nurses, and other health manpower.**

Walter A. Sodeman, chairman of the AMA's Council on Medical Education, told the Senate Health Subcommittee that the AMA supports the continued expansion in enrollment of medical school students because "the urgent need for more physicians persists."

"To achieve expanded enrollment it will be necessary to have increased financial support from both government and private sources for the construction of additional facilities at existing schools and creation of new schools," he said. "Equally important will be increased support for the operational costs of medical schools and for education improvement and innovation which could shorten the time required for medical education."

Dr. Sodeman said that while the AMA strongly favors continued federal financial aid for the operation of medical schools, the association believes the capitation figure should be \$3,500 instead of the proposed \$5,000. The AMA also doubts the wisdom of tying institutional grants to expansion of student enrollment, he said.

"While expansion is certainly desirable in view of the urgent need for more physicians, we have some concern about conditioning operational support to expansion," he said. "There are currently some medical schools in severe financial straits. Some are facing the real danger of being unable to keep their doors open. These schools need increased operational support to maintain their present facilities and activities, and a requirement that they must increase the student load in order to qualify for such support may serve to defeat the purpose of the program."

\* \* \*

## Did You Know?

- Insurance companies paid out some \$7.5 billion in health insurance benefits in the United States in 1969.

- It was an increase of 12% over the \$6.7 billion paid a year earlier, and a record high in benefit payments.

- Health insurance benefits over the past ten years have risen, from \$2.8 billion to 1969's \$7.5 billion.

- Benefits paid over the past 20 years have increased 15-fold, up from \$507 million.

- In 1969, benefits rose in every major health insurance category.

- Hospital expense insurance was up from \$2.6 billion to \$2.8 billion while medical expense insurance rose from \$296 million in 1968 to \$375 million in 1969.

- Major medical expense insurance recorded the largest increase, rising from less than \$1.7 billion to \$1.9 billion during the year.

- Disability income insurance benefit payments were up nearly over \$200 million to a \$1.6 billion total.

- Surgical and dental expense insurance rose to \$800 million, a \$44 million gain.

- Of all the benefits for health care expenses paid by insurance companies, \$3.5 billion went for hospital bills, while physicians, surgeons, and dentists accounted for nearly \$2.4 billion.

- Total benefits paid the American public by all health insuring organizations in 1969 reached an estimated \$13.5 billion—highest amount ever paid in a single year.

- Medical expense insurance, which helps pay for nonsurgical care by physicians, protects an estimated 136 million Americans.

—Health Insurance Institute





NEIL SOLOMON, MD, PhD, SECRETARY

## Maryland State department of health and mental hygiene

# New Guidelines For Admission Of The Aged To State Mental Hospitals

About 2,000 aged persons are now cared for in Maryland's state mental hospitals. Many of them were admitted in old age for a variety of medical and social needs, rather than primarily for psychiatric treatment.

By serving as a substitute for services and facilities unavailable in the community, the mental hospitals are impeded in offering optimum care for those aged who do need psychiatric treatment, and provide a poor alternative for those who do not.

To aid the aged, their families, community organi-

zations, and referring physicians in making the best use of the state mental hospitals and alternative resources, if indicated, the Department of Health and Mental Hygiene has established the following:

1. Criteria for Admission of the Aged to State Mental Hospitals: Recognizing that appropriate alternatives are limited, the Department has deliberately worded the Criteria (except for the section on Clearly Inappropriate) to permit flexibility in working out a plan in the patient's best interest.

### Criteria For The Admission Of The Aged To Maryland State Mental Hospitals

#### I. Clearly Appropriate

A. Those with functional psychoses without significant physical illness or disability for whom outpatient treatment is not feasible.

Examples:

1. Patients receiving psychiatric treatment in the community who require brief periods of protection from the consequences of their behavior during episodes of acute disturbance or depression, ie, suicide, homicide, spending sprees, refusal to eat.

2. Chronically mentally ill patients who require protection and management, as well as treatment, during prolonged periods of disruptive or disorganized behavior, requiring regular and frequent attendance of a physician.

B. Alcoholics without significant physical illness or disability who, following detoxification, need a period of inpatient treatment for their alcoholism.

C. Those with severe organic brain disease whose usual behavior, intractable to medication, is too disturbing to be managed at home or in another facility. Examples: the physically aggressive patient, fire-setter, eloper, or person otherwise dangerous to himself or others when **physically able** to carry out this potentially destructive behavior.

#### II. Clearly Inappropriate

A. Those with acute brain syndrome which is symptomatic of a grave physical illness, requiring urgent admission to a general hospital.

B. Those who are moribund or comatose.



C. Those with major medical problems and minor mental symptoms. Examples: patients who become mildly confused or disturbed as a result of or in conjunction with recent head injury, cardiovascular disease, diabetes, metabolic disturbance, terminal malignancy, etc. Psychiatric consultation might be utilized, if required, rather than mental hospital admission.

D. Those with inconsequential lapses of memory and mild disorientation as a result of chronic brain syndrome are more effectively treated or managed in their own homes, or, if necessary, in a foster home, home for the aged, etc. A state mental hospital has little to offer and, in view of large wards in most state mental hospitals, may aggravate the patient's confusion.

E. Those who need only adequate living accommodations, economic or other social support services.

### III. Individualized Assessment

In the following situations, various factors have to be weighed to determine the course of action best suited to the patient's needs. If doubt exists about the etiology of the patient's behavioral disturbance or if he is also suffering from a physical ailment more severe than the mental disorder, admission to a mental hospital should be deferred until a complete medical evaluation is made, if necessary by admission to a general or chronic disease hospital.

A. Those with reversible psychiatric illness accompanied by serious medical problems may be admitted if the general hospital has no psychiatric ward or other psychiatric service **and** if the mental hospital has the capacity to treat the medical condition.

B. Those with chronic brain syndromes should be assessed in terms of the potential efficacy of psychiatric treatment and management, the degree of behavioral disturbance, and the resources of family and social situation.

#### Examples:

1. During episodes of agitation and restlessness produced by a stress situation, they may require brief mental hospital admission.

2. Those with moderate or advanced symptoms require careful evaluation of their potential for improvement. They are evaluated most effectively in their familiar setting but may, when home factors are detrimental, require assessment in a controlled environment which may be a mental hospital.

3. Temporary admission for senile patients cared for by the family may be considered to provide relief to the family and permit a comprehensive evaluation of the patient.

2. Modification of Admission Procedure: a. Prior to mental hospital admission, all aged patients (65

years of age and older) from Baltimore city and Baltimore County should be referred for preadmission evaluation to geriatric evaluation units in the local health departments.

Geriatric evaluation teams are functioning in only these two subdivisions at present but will become available in other counties. The evaluation team maintains close contact with the patient's personal physician in making a full assessment (social as well as medical or psychiatric) of the patient in his own home, advising about alternative resources if indicated, and assisting those concerned to obtain these services. If mental hospital admission is recommended, the information gathered is made immediately available to the hospital. Wherever practicable, an effort is made to maintain the patient in his own home.

Referral may be made by telephone or, in the case of physicians, by mailing completed form SHD 29 (used for nursing home approval) with accompanying certificate.

For **Baltimore city** residents, contact:

Geriatric Evaluation Service  
Good Samaritan Hospital  
5601 Loch Raven Blvd.  
Baltimore, Maryland 21212  
Telephone: 323-2200, ext. 279, 286, 267

For **Baltimore County** residents, contact:

Comprehensive Geriatric Program  
Baltimore County Health Department  
Jefferson Building  
105 W. Chesapeake Avenue  
Towson, Maryland 21204  
Telephone: 494-2733

For emergencies occurring during evenings or weekends, call the admitting physician at the appropriate state mental hospital.

b. In all other subdivisions, follow established Hospital Admission Procedures contained in the instructions accompanying the physician certificate forms: "The relative, a family physician, or public official who is responsible for the decision to admit the patient to a mental hospital shall first call the Preadmission Service of the hospital."

In general, family members and referral sources should bear in mind that the patient will remain in the hospital only as long as psychiatrically indicated, namely, while such hospitalization can be expected to benefit the patient by effecting clinical recovery or, at least symptomatic improvement. Mental hospitalization, like admission to any hospital, is not intended as a permanent arrangement.

Your cooperation in observing the criteria and modifications in admission procedure is earnestly requested.

James E. Carson, MD  
Commissioner  
Department of Mental Hygiene





ROBERT E. FARBER, MD, MPH, COMMISSIONER

## **Baltimore City health department**

# **Highlights**

## **Alcoholism Group for Women**

In an effort to help women who are alcoholics, the Baltimore City Health Department's Alcoholism Center has established a Women's Counseling Alcoholism Group.

Under the leadership of Mrs. Emma L. Douglas, a City Health Department alcoholism counselor, the group meets every Wednesday at 1:30 PM at the Alcoholism Center, 2221 St. Paul St., in Baltimore.

Open to all women with a drinking problem, the group now has an enrollment of 22 women alcoholics. Physicians who may need help with women alcoholic patients may get additional information by calling Dr. Abraham M. Schneidmuhl, Director, Alcoholism Center, 752-2000, ext. 2756. Both group and individual counseling are available.

Mrs. Douglas, a Baltimore resident, received her alcoholism counselor certificate in 1969 in the department's training program. She has had assignments working with men and women alcoholics at Spring Grove State Hospital and Baltimore City Hospitals. Presently, she is assigned to the Eastern District Municipal Court and works with alcoholics in the community through the Baltimore City Community Action Agency. A graduate of Dunbar High School, Mrs. Douglas is continuing her education at the Community College of Baltimore, where she is majoring in mental health education.

According to Mrs. Douglas, most of the women who have participated in the group activities feel that they are being helped with their drinking problem.

## **Mrs. Ramsey Appointed Nursing Consultant For Family Planning**

The Baltimore City Health Department has added a new nursing consultant to its Family Planning unit to help with the expanding work of the Maternal and Child Health Services section. Mrs. Elizabeth Ramsey, formerly a public health nurse in the Western Health District, will be a resource person and will coordinate services for the department's family planning programs.

Mrs. Ramsey received her master's degree in community mental health from the University of Maryland in 1970. Her bachelor's degree in nursing is from the University of Washington in Seattle.

The City Health Department's Family Planning unit is designed to help the family achieve a healthy family life, since family attitudes are a vital part of the community's total health. Currently expanding its contacts with community groups, the Family Plan-

ning unit also will be developing more inservice education for City Health Department personnel.

Family Planning services include methods of contraception, family counseling, and some social services. Family Planning may also refer men and women to other services in fertility, sterilization, prenatal programs, or social services.

Funded by the U.S. Health Services and Mental Health Administration with matching city funds, the city's Family Planning program served 14,000 Baltimoreans during 1970. Services are available to residents in each of the five health district buildings and in clinics at 2700 Spelman Road in Cherry Hill, 4200 Edmondson Avenue, and at 1817 E. Baltimore Street. Additional information on Family Planning may be obtained from the Baltimore Maternity Center, 211 W. Lombard Street, telephone 752-7282.



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**Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous

eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

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**Dosage Forms:** Oral tablets . . . 250 mg.  
Vaginal inserts . . . 500 mg.

\*References available on request.

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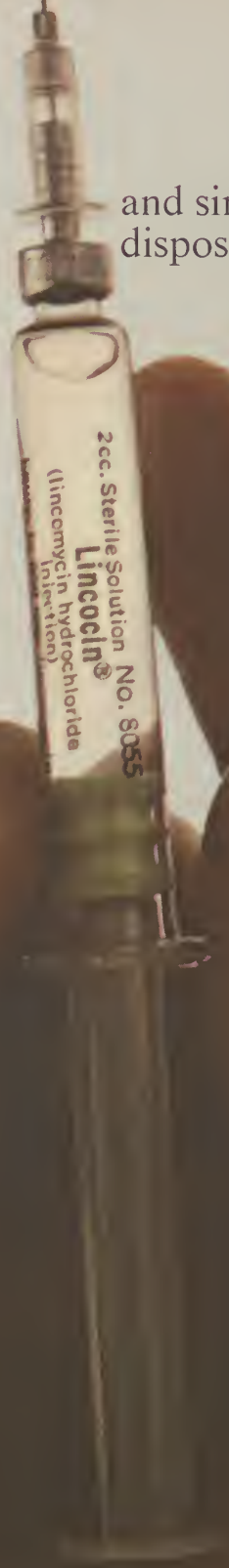
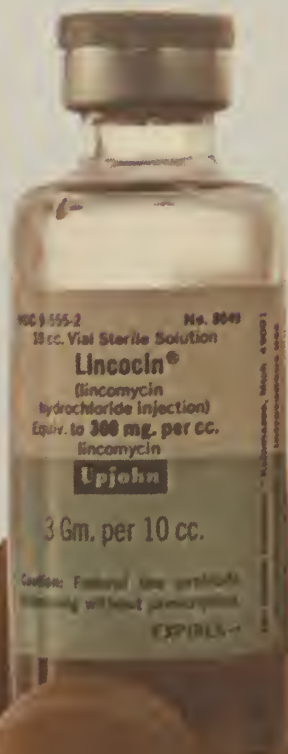
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Numerous operations have been devised for repair of hypospadias, but many of the present procedures carry with them a significant rate of such complications as fistula formation, stenosis, and wound breakdown. Also, many are two-stage procedures.

In the spring of 1968, while visiting Marquette University School of Medicine, Dr. Scott observed the splendid results achieved by Norman Hodgson using a one-stage repair. Here was a procedure which answered most of the criteria of an ideal procedure: release of chordee, construction of a new distal urethra existing near the tip of the glans, the fact that it was one-stage, and relative freedom from complications.

We will present our fortunate experience using the Hodgson repair. Since we began to use his method, Hodgson has published his results.<sup>1</sup>

## Hypospadias:

# Experience with a New One-Stage Repair

## (Hodgson Urethroplasty)

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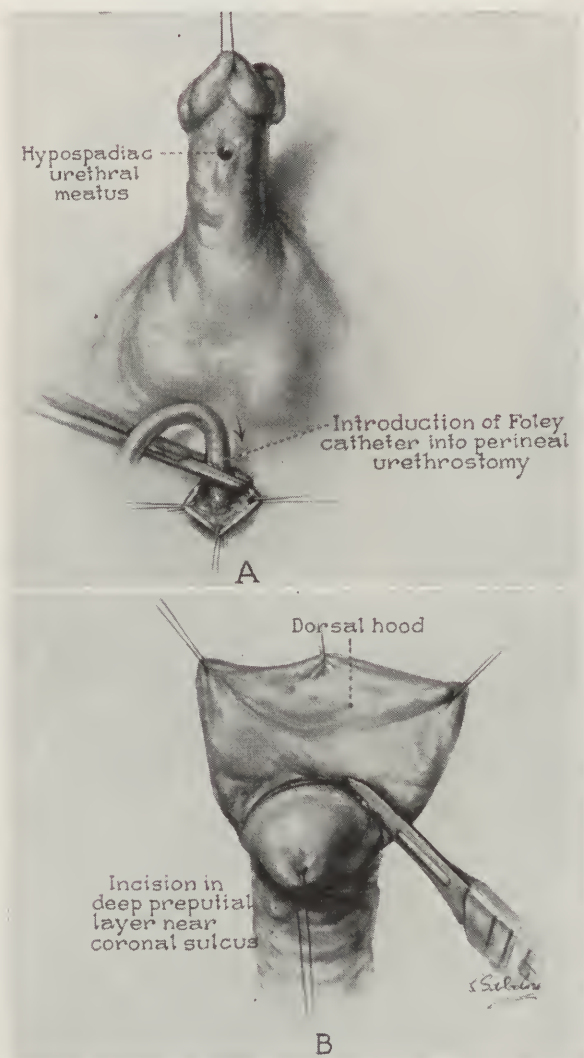


The method to be described is essentially that described by Hodgson for hypospadias occurring in the distal third of the penile shaft, with minor changes which we have made as we have gained experience. The illustrations by Leon Schlossberg are drawn from a movie of the procedure produced by Hodgson.

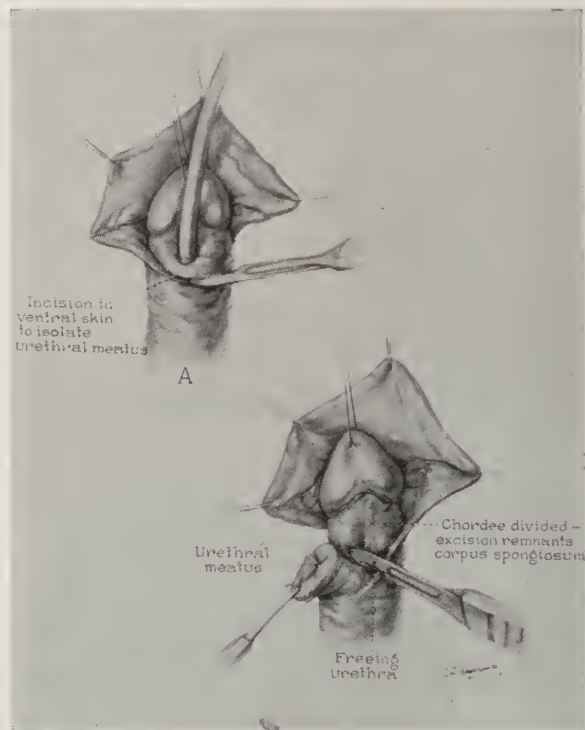
After dilation of the hypospadiac meatus, the urine is diverted with a #14F balloon catheter introduced into the bladder through a perineal urethrostomy, as shown in Figure 1-A. It is held in place by inflating the balloon and placing a suture of silk or nylon through the edge of the skin incision and then tying it around the catheter.

The incision in the deep preputial layer begins in a circumferential line just below the coronal sulcus (Figure 1-B). It is extended through the skin of the ventrum of the shaft to the point of beginning

**Figure 1: (A) Insertion of catheter into perineal urethrostomy; (B) Circumferential incision at coronal sulcus**



on the dorsal surface (Figure 2-A). The hypospadiac meatus is circumscribed. This is done by making a triangular incision whose base is at the coronal sulcus, and whose long limbs meet in the midline just below the urethral meatus. Then, all fibrous tissue causing chordee is excised down to the tunica albuginea of the corpora cavernosa, and far enough laterally to completely release the chordee (Figure 2-B). The distal urethra is mobilized if necessary.



**Figure 2: (A) A continuation of circumferential incision; (B) Excision of chordee and mobilization of distal urethra**

We then place three stay-sutures through the dorsal hood, rather than using skin hooks. These are placed at points where the deep and superficial preputial layers meet, two at each lateral margin and one in the midline. Parallel incisions are then made through the deep preputial layer of the hood, as shown in Figure 3. These extend from the base of this layer toward the junction of the deep and superficial layers. This deep preputial tissue will become the new urethra. These incisions are through the cutis only, and should avoid all blood vessels. The width of this flap should be about 2 cm. wider in older children, and the length adjusted to bridge the gap between the circumscribed hypospadiac meatus and the tip of the glans penis. The redundant deep preputial layer lateral to the flap is excised. The dorsal skin of the penis is then separated by blunt dissection from the shaft with scissors, for two thirds of the length of the penis.



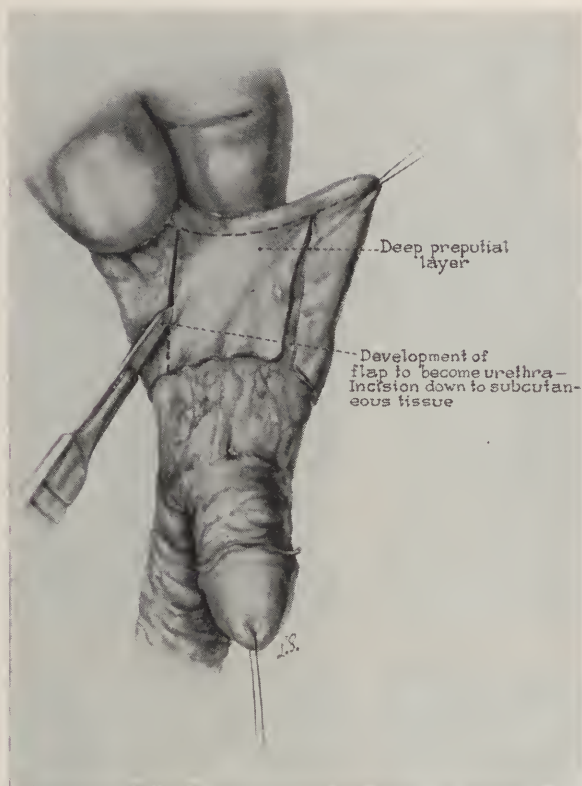


Figure 3: Delineation of deep preputial skin flap

Next, a buttonhole is made through the skin of the dorsum of the penis, permitting the glans and distal shaft to be pulled through this buttonhole. This incision is in the midline with lateral relaxing incisions made, if necessary, after the pull-through. A stay-suture through the tip of the glans helps in this maneuver (Figure 4-A, 4-B).

As shown in Figure 5-A and 5-B, a tube is made from the deep preputial flap. This is done around a silicone (*Silastic*) stent. The sutures used are interrupted 6-0 chromic catgut. They are carefully placed through the subcutaneous tissue just beneath the lateral margins of the flap but not through it.

The new urethra is now joined to the circumscribed urethral meatus, the latter trimmed to size (Figure 5-B). The same suture material is used as in rolling the flap. The posterior surface is outlined first after the flap has been turned over. This maneuver brings the suture line of the new urethra into the groove between the corpora cavernosa, away from the ventral skin covering, and thus reduces the chance of a fistula.

Figure 5: Rolling of urethra from preputial flap: (A) shows the initial suture being placed; (B) shows the completed formation of new urethra just prior to anastomosis to old urethral meatus

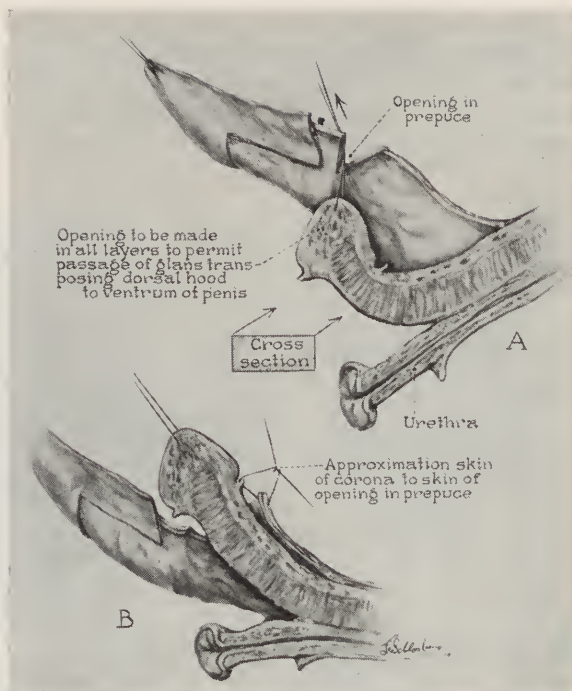
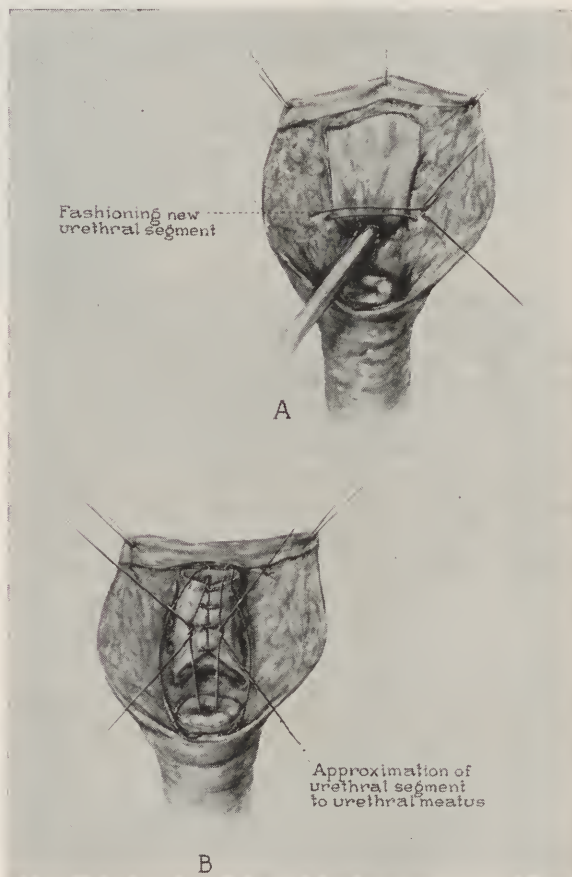


Figure 4: Cross-section of penis with preputial flap, showing the buttonhole: (A) shows the view before, the glans is being pulled through the buttonhole; (B) shows the completed pull-through





Small wedge incisions are then made into the penile glans. These run about 2 mm parallel to the midline of the urethral groove, bilaterally. The external meatus of the new urethra is sewn to the medial margin of these lateral incisions (Figure 6-C).

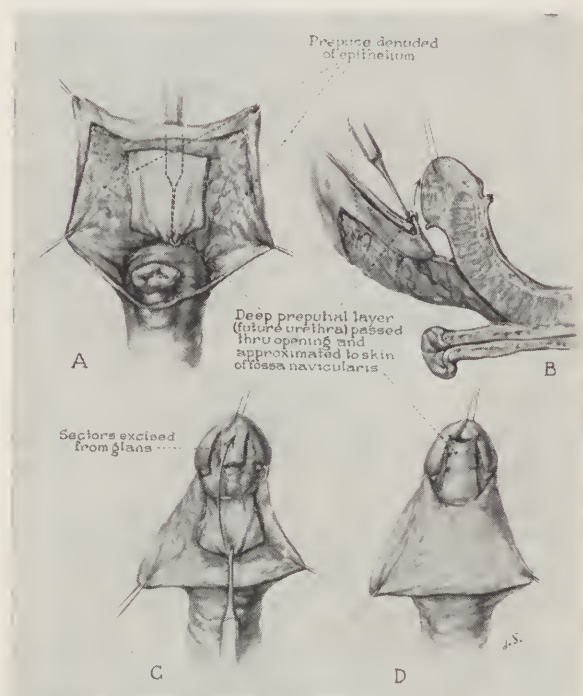


Figure 6: (A) shows the deep preputial flap before rolling the tube; (B) shows the same in a cross-section; (C) shows excision of the glandular wedges; (D) shows that the preputial flap has been sewn into the glandular wedges, thus forming the new external urethral meatus

The penile skin is closed with interrupted 5- to 6-0 nylon sutures after the redundant lateral "dog-ears" have been resected (Figure 7). At the new meatus, the skin is also sewn to the lateral margins of the wedge incisions in the penile glans (Figure 6-D). The holding-suture through the tip of the glans is used to tie in the urethral stent and is then sewn into the anterior abdominal wall. Adequate hemostasis is most important throughout the procedure. Sponges soaked in a 1:100,000 solution of epinephrine and applied to the wound aid in hemostasis, and fine bleeding-points are then coagulated with the cauterizing needle. At the close of the procedure, we cover the wound with Adaptic and apply a very light protective dressing. We believe that a pressure dressing should **not** be used, as complications frequently seen following urethroplasty may be due in part to compression of the vascular supply by these dressings. Bed rest is compulsory for the first few days.

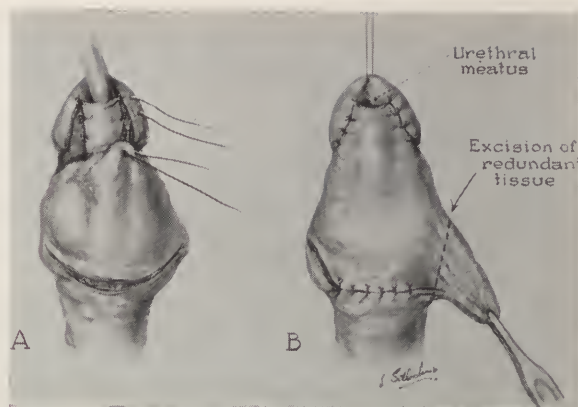


Figure 7: Closure of penile skin and resection of redundant lateral "dog ears"

Sutures and urethral stent are removed on the tenth postoperative day; the balloon retention catheter is removed the following day.

## Results

Between May 1969, and June 1970, we performed 18 urethroplasties using the method described. Three of these patients had previously undergone a partial circumcision of their dorsal hood. The results of our repair using this type of urethroplasty have been very satisfactory (see Figure 8).

No patient developed a wound breakdown or infection. One patient developed a small fistula at the site of the anastomosis of the hypospadiac meatus to the new urethra and eventually formed a stenosing scar in this area. During the next year, it was necessary to perform a two-stage Johanson urethroplasty; presently, this patient is doing very well.

A small fistula at the anastomotic site occurred in another patient and was closed surgically. No stenosis of the newly-formed urethra occurred, but a mild stenosis at the juncture of old and new urethra was seen in two other patients. One of these also had a meatal stenosis. These stenoses were dilated easily, under sedation or general anesthesia, and have not required further instrumentation. Two additional patients with meatal stenosis were seen; one has been dilated satisfactorily, while the other required a meatotomy. Both have done very well.

## Summary

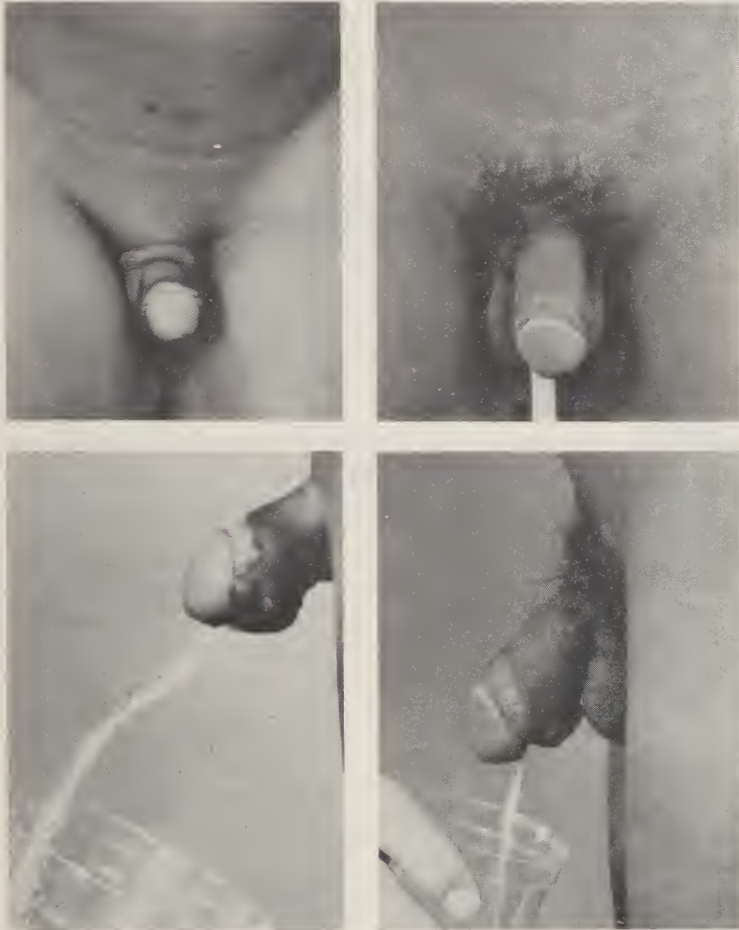
Eighteen patients underwent a Hodgson urethroplasty for hypospadias with chordee. Five patients developed some degree of urethral stenosis, two at the new meatus, two at the anastomotic site of the new to the old urethra, and one at both sites. Two patients developed a fistula at the anastomotic site, one of whom is a patient who also developed stenosis



at the anastomotic site. Thus, a total of six patients developed complications. Three of these had to be repaired surgically.

The Hodgson one-stage urethroplasty appears to

be the urethroplasty of choice for surgical correction of hypospadias occurring in the distal third of the penile shaft. The complications are minimal, and the results are very satisfactory.



**Figure 8: AP and lateral views of two representative patients, the lateral view showing the patient during micturition**

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#### REFERENCE

1. Hodgson, N. B.: A One-Stage Hypospadias Repair, *J Urol* 104:281-3, August 1970.



# Acute Streptococcal Pericarditis:

## Report of a Case Treated

## with Pericardiectomy

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Acute pyogenic pericarditis is still a life-threatening illness with a current mortality rate of about 20%.<sup>1</sup> The relative merits of medical vs surgical therapy are still open to controversy. In recent years pericardiectomy has been proposed for patients with recurrent, idiopathic, "benign" pericarditis for relief of effusion and pain, and to prevent late constriction.<sup>2-7</sup> However, antibiotics together with needle aspiration or open drainage, or both, has usually been the recommended treatment of acute pyogenic pericarditis.



This article concerns a patient with beta hemolytic streptococcal pericarditis initially treated with needle aspiration and antibiotics, but in whom recurrent tamponade with evidence of a thickened pericardium was successfully treated with pericardiectomy in the acute stage of the disease.

### Case Report

H. R. (USPHS #285-507), a 47-year-old man, was admitted to the Baltimore USPHS Hospital for the first time on April 7, 1970, with a complaint of chest pain and shortness of breath. He had a "flu-like" syndrome several months prior to admission and subsequently noted anorexia and weight loss of 30 to 35 lb. However, he denied all other respiratory and cardiac symptoms until one month prior to admission. At this time, left precordial chest pain began, which was worse in the supine or left lateral decubitus position. He specifically denied sputum production, chills, diaphoresis, or exposure to tuberculosis.

Admission examination revealed a blood pressure of 135/95 with no significant pulsus paradoxus, pulse 114, and temperature 100.4 F. The neck veins were only mildly distended. There was dullness to percussion and decreased breath sounds at both lung bases posteriorly. No rales were heard. The left border of cardiac dullness was markedly shifted to the left with an imperceptible impulse. There was a Gr. II/VI systolic ejection murmur at the left sternal border, but no rub, gallop, or knock was heard. The liver was slightly enlarged. There was no peripheral edema.

On April 8, 1970, the WBC was 8,600 and Hct. 34. Three blood cultures taken within 24 hours of admission were negative. The admission chest X-ray (Figure 1) demonstrated marked enlargement of the cardiac silhouette both to the left and right, consistent with a pericardial effusion. The electrocardiogram (Figure 2) was compatible with pericarditis showing ST elevation in leads I, II, aVL, and V<sub>6</sub>. A tuberculin skin test was negative. Venous angiography on April 8, 1970 confirmed the presence of a pericardial effusion.

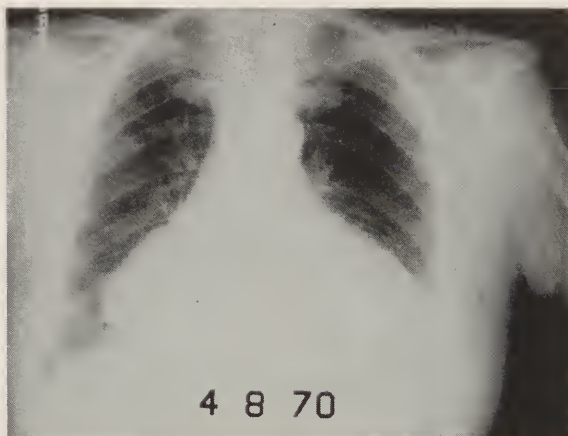


Figure 1: Admission posterior-anterior chest X-ray demonstrating enlargement of the cardiac silhouette both to the right and left consistent with pericardial effusion

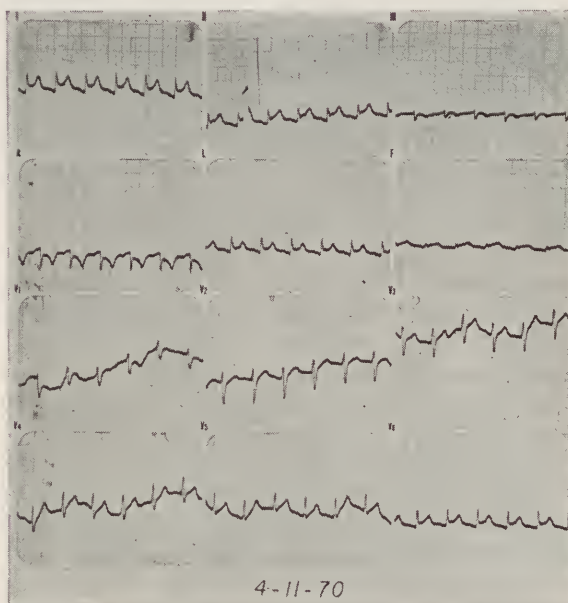


Figure 2: Admission electrocardiogram showing ST elevation in leads I, II, aVL, and V<sub>6</sub> consistent with acute pericarditis

### Fourth Hospital Day

On the fourth hospital day, there was marked increase in dyspnea, fall in blood pressure to 80 systolic with 12 mm paradox, neck vein distension, and a pericardial friction rub. Temperature remained between 100 and 102 F and WBC 8,000 to 13,000. On pericardiocentesis, 1,000 ml of turbid, slightly bloody fluid was removed and 100 cc of air was injected (Figure 3). The fluid contained 25,500

WBC, 6 gm % protein, and 20 mg % glucose (peripheral blood glucose—154 mg %). Gram-positive cocci were seen on smear which later proved to be *β*-hemolytic streptococci. The patient was started on methicillin 1 gm every six hours. Following the pericardiocentesis, the patient was markedly improved, and his blood pressure returned to that demonstrated on admission.





**Figure 3:** Chest X-ray following pericardiocentesis with installation of 100 cc of air in pericardial sac. Note the thickened parietal pericardium

However, two days later, signs of tamponade recurred, requiring another pericardiocentesis of 1,000 ml of thick purulent fluid which again grew out  $\beta$ -hemolytic streptococci in spite of 48 hours of intensive antibiotic therapy. Temperature remained elevated to 102 F, and WBC was 10,400. Because of the failure to respond to conservative therapy, surgical drainage was considered. With the already thickened pericardium and exudative nature of the fluid, constrictive pericarditis was felt to be a possible late sequela; therefore, pericardiectomy was recommended. This was performed through a left anterior-lateral thoracotomy incision under fluothane anesthesia with continuous monitoring of ECG, arterial pressure, and central venous pressure. The pleural space was entered through the fifth interspace dividing the sixth rib posteriorly and the fifth costal cartilage anteriorly.

After opening the chest, a tense inflamed pericardial sac was seen which, when opened, revealed a thick shaggy exudate on both the visceral and parietal surfaces (Figure 4). The heart was moderately enlarged. Three hundred milliliters of thick purulent fluid was removed from the pericardial sac which was sterile on culture. A parietal pericardiectomy on the anterior surface and left side of the heart down to the pulmonary veins was performed. Due to limitations of exposure from the left thoracotomy and the enlarged heart, the parietal pericardium on the right was removed down to about 2 cm from the pulmonary veins. The peel of exudate over the heart was similarly removed in an area comparable to the extent of the excised parietal pericardium (Figure 5). Irrigation of the heart and chest wound was performed using 0.5% neomycin-bacitracin solution, and a chest tube was inserted in each pleural cavity. Chromic catgut was used to close the chest wall, and the patient was given 12 million units of intravenous penicillin daily.



**Figure 4:** The pericardial sac has been opened. Clamps are on the cut edge of the markedly thickened parietal pericardium. Note also the extensive thick shaggy exudate over the epicardial surface of the heart



**Figure 5:** A view of the moderately enlarged heart after removal of the exudate covering the epicardium. The Deaver retractor shown at the bottom of the figure is retracting the left lung

The postoperative course was benign except for an allergic rash from penicillin which appeared on the third postoperative day requiring a change to erythromycin, which was continued for 2½ weeks postoperatively. When seen in the clinic six weeks following surgery, the patient was completely asymptomatic. Blood pressure was 120/80, with no para-



dox. Cardiac examination was essentially normal. Follow-up ECG was normal (Figure 6). Chest X-ray showed only minimal enlargement of the cardiac shadow (Figure 7).

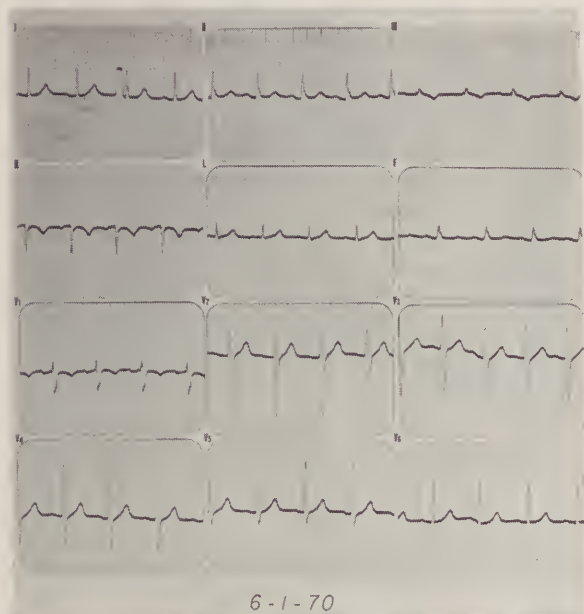


Figure 6: Essentially normal electrocardiogram six weeks postoperatively



Figure 7: Posterior-anterior chest X-ray six weeks postoperatively showing marked decrease in size of cardiac silhouette

### Discussion

Purulent pericarditis is a relatively rare disease with a reported autopsy incidence of 0.1% to 0.7%. Most reported cases have been in men (77%) and over half are under the age of 20. *Staphylococcus* has been the most common cultured etiologic organism (26%), followed by *pneumococcus* (20%), and finally, *streptococcus* (10%). The mortality rate in the preantibiotic era was over 50%, but since the advent of penicillin has been about 20%.

The usual form of therapy has been repeated needle aspiration or open drainage, together with the appropriate antibiotics. Crastopol and associates reported a case of acute staphylococcal pericarditis treated with anterior parietal pericardiectomy because of persistent fever and signs of restricted cardiac filling.<sup>4</sup> Other cases of acute pyogenic pericarditis have subsequently been treated with pericardiectomy with good results.<sup>8-12</sup> The indications for pericardiectomy over open drainage have been inability to obtain complete drainage with pericardiectomy, acute constriction due to rapid thickening of the pericardium, and the hope of preventing later constriction.

The frequency with which purulent pericarditis leads to constriction appears to be rather low.

Deterling and Humphreys reported no cases of constriction among 59 patients with purulent pericarditis with follow-up to 20 years. Of 25 cases of constrictive pericarditis, none were thought due to a pyogenic infection.<sup>13</sup> Gersony and McCracken<sup>14</sup> were able to find no case of constrictive pericarditis as a sequela of purulent pericarditis in infancy. Duration of follow-up was not given. Boyle and associates<sup>1</sup> found among 274 patients with chronic constriction only 16 who had a septic illness consistent with possible purulent pericarditis. However, they also reported ten cases of "acute" constriction developing within a few months of the pyogenic infection. Horan<sup>15</sup> reported no case of constriction developing in five survivors of purulent pericarditis with follow-up of one to ten years. Shipley and Winslow<sup>16</sup> reported two cases of symptomatic constrictive pericarditis among 35 cases of purulent pericarditis followed for one to thirty-two years. Blalock and Burwell<sup>17</sup> reported that of 28 cases of constrictive pericarditis, three were due to staphylococcal infection.

The relatively low reported incidence of chronic constriction following purulent pericarditis is probably not an accurate estimate of the current prog-



nosis. Many of the above reported cases were in the preantibiotic era or early in the antibiotic era, when the mortality rate was 50% or more. It is likely that many patients with more severe pericardial involvement did not live long enough to develop typical constrictive pericarditis. The actual incidence of late constriction in purulent pericarditis with current treatment is not known. It is reasonable to predict that with the intense inflammation and exudation, as seen in our case, late constriction may occur.

This case, together with those previously reported,<sup>8-12</sup> demonstrate that pericardiectomy can be performed during the acute stage of the illness. From a technical standpoint, pericardiectomy at this time is certainly easier than when the visceral and parietal surfaces have become densely adherent. We do not propose that pericardiectomy be performed in

all cases of purulent pericarditis. However, in selected cases where early thickening of the pericardium is noted, as in this case, and where open or closed drainage is inadequate, pericardiectomy should be performed and should prevent any possibility of late constriction.

### Summary

A 47-year-old man with acute streptococcal pericarditis from an unknown source, who did not respond to needle aspiration and appropriate antibiotics, was successfully treated with pericardiectomy in the acute stage of the disease. Those patients with purulent pericarditis who do not respond to more conservative treatment or who show early thickening of the pericardium or early constriction should be treated with pericardiectomy, which should prevent late constriction.

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# Maryland Law

and

# Blood Transfusion

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In February 1967, a patient received blood at The Johns Hopkins Hospital, and subsequently developed hepatitis. He brought suit against The Johns Hopkins Hospital. In January 1971, the case was decided in the hospital's favor. A well annotated 44-page opinion in this case described and commented on the law in three areas: negligence, breach of warranty, and strict liability in tort. Citations include legal precedent in several states, the Uniform Commercial Code (accepted by the Maryland legislature as part of the code of the state of Maryland, and therefore binding in Maryland), and the Restatement of Torts, a document drafted by the prestigious American Law Institute. This latter is generally conceded to have weight in court, second only to case law.

The principles adduced from this opinion are important not only in blood banking, but may influence the whole of medical practice in the state of Maryland.



The plaintiff, John J. Schuchman, filed suit against The Johns Hopkins Hospital after contracting serum hepatitis during his hospital stay which commenced on February 23, 1967. The hepatitis was allegedly caused by transfusion of blood contaminated with hepatitis. Attorneys for both plaintiff and defendant agreed:

1. That the plaintiff received the blood for medically appropriate reasons;
2. That one or more of the units of blood were contaminated with a hepatitis agent which caused the hepatitis in the plaintiff;
3. That the defendant did not depart from medically accepted practice in the collection, storage, or transfusion of this blood.

Both counsels then asked for a stay of proceedings to allow the court to define a question of law. The question in this case was whether the defendant is either strictly liable without fault, or liable by reason of breach of implied warranty in the sale of blood (as distinct from the rendering of a service).

Judge J. O'Donnell of the Superior Court of Baltimore City handed down a decision on the question of law in three parts: negligence, implied warranty, and strict liability in tort.

### Negligence

In a brief discussion of negligence, the court commented upon recent statements in the popular press regarding testing for the Hepatitis Associated (Australia) Antigen, and concluded:

There is no evidence here in this case that any such test was available to the defendant in February 1967, or, if it were, whether it was accepted hospital procedure to have such test used before administering blood units to hospital patients.

Evidence of the availability of such a test, or a similar procedure, would create an issue for a jury . . . of malpractice on the part of the defendant.

### Implied Warranty

Warranties in law exist only with an actual or implied sales contract. To determine whether an implied warranty existed in this case, the court first examined the question of whether there was a sale. Precedent opinion in other jurisdictions was extensively evaluated, particularly recent Florida decisions that hospital blood transfusions represented a *service*, not a sale, and that therefore no implied warranty existed. Judge O'Donnell states:

Again, in 1960, in *White v. Sarasota County Public Hospital Board*, 206 So. 2d 19, the District Court of Appeals of Florida held that the transfer of blood by a *hospital* as contrasted to a "blood bank"—was not a "sale" but a "service" and there was no implied warranty of fitness or

merchant ability . . . The [Florida Appellate Court] reiterated the recognized distinction between the applicability of warranty in the sale of the commodity of blood by a [commercial] blood bank as contrasted to the supply of a service by the hospital. The Court held that *both* the blood bank and the hospital could be liable for negligence but that the hospital could not be liable "for breach of implied warranty."

Judge O'Donnell then cited the Uniform Commercial Code as additional evidence that the hospital is not a merchant. Comment 2 under §2-314, of the Uniform Commercial Code, Sales, (Art. 95B, §2-101 ff.) provides ". . . Goods delivered under an agreement made by a merchant in a *given line of trade* must be of a quality comparable to that generally acceptable in that line of trade to the description or other designation of the goods used in the agreement." Comment 3 to the same section (2-134) provides: ". . . A person making an *isolated sale* of goods is not a 'merchant' within the meaning of the full scope of this section and thus no warranty of merchantability would apply . . ."

Judge O'Donnell states:

It is difficult to conceive that [Johns Hopkins Hospital] was a "merchant" with respect to the administering of the four units of concentrated red blood cells [since the Defendant is not in that given line of trade] . . .

. . . If, indeed, the supplying of the four (4) units of blood to the Plaintiff can, by rigid definition, be considered a "sale," it would of necessity be an "isolated sale" and in regard thereto, the hospital could not be considered a "merchant" and no warranty of merchantability would apply.

When one considers that blood is transfused into a patient mechanically by tubing and needle attached thereto from its container into a vein of the patient, the concept of a "service" rather than a "sale" is buttressed.

Even if blood transfusions were still considered to be a sale, despite decisions in other jurisdictions and evidence to the contrary from the Uniform Commercial Code, there is not necessarily an attached warranty. The Restatement (Second) Torts of the American Law Institute, (Sec. 402A, Comment K), provides as follows:

*Unavoidably unsafe products.* There are some products which, in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use. These are especially common in the field of drugs. An outstanding example is the vaccine for the Pasteur treatment of rabies, which not uncommonly leads to very serious and damaging consequences when it is injected. Since the disease itself invariably leads to a dreadful death, both the marketing and the use of the vaccine are fully justified, notwithstanding the unavoidable high degree of risk which they involve. Such a product, properly prepared, and accompanied by proper directions and warning, is not defective, nor is it *unreasonably dangerous*. The same is true of many other



drugs, vaccines, and the like, many of which for this very reason cannot legally be sold except to physicians, or under the prescription of a physician. It is also true in particular of many new or experimental drugs as to which, because of lack of time and opportunity for sufficient medical experience there can be no assurance of safety, or perhaps even of purity of ingredients, but such experience as there is justifies the marketing and use of the drug notwithstanding a medically recognizable risk.

In applying the principle of this *Comment to the Restatement of Torts*, the Florida Appellate Court (*Russell vs. the Community Blood Bank, Inc.*, 185 So. 2d 749 (Fla. app.) 1966) stated:

However, should the product be one which cannot be made absolutely safe, but is nevertheless essential to human health, and where its use is prescribed by a physician who is made fully aware of the risk of harm, but who, in his sound medical judgment, believes that taking the risk is justified, then the fact that there is an unavoidable defect in a certain percentage of the product will not result in a breach of warranty. See Restatement (Second), Torts, Sec. 402A, Comment (k). This could be the case with blood supplied by a blood bank, and, if so, then proof that the defect in blood is undetectable and unremovable would be a defense to breach of implied warranty. However, the burden of this proof would be on the blood bank.

To summarize regarding implied warranty, Judge O'Donnell stated:

The overwhelming weight of authority requires the Court to answer that there is no liability on the part of the Defendant, Johns Hopkins Hospital, to the Plaintiff by reason of the breach of an implied warranty in the "sale of blood." All the cases are "legally virtuous" that the furnishing of blood by a hospital is a service not a sale and the supplying of the blood is incidental to the medical service supplied.

### Strict Liability in Tort

The concept of strict liability in tort, as applied to manufactured goods, has been recognized in this country for 50 years. Its recent expanding application, however, may well be related in part to an article by Professor William L. Prosser entitled "The Fall of the Citadel (Strict Liability to the Consumer)", published in 69 Yale Law Journal 1099 (1960). Professor Prosser has long been a recognized authority in this area, and author of a standard textbook, *Prosser on Torts*. His article discussed the risk distribution theory, and its actual application in contracts and torts.

The risk distribution theory, that the supplier should be held liable for malfunctioning of a product because he is in a position to insure against liability and add cost to the price of his product, had limited application because liability traditionally depended upon warranty, real or implied. War-

rancies, in turn, existed only where there was a legal contract, and a warranty was attended by contract rules.

No one disputed that where there was a warranty, strict liability for malfunction existed under contract law. If there was no legal contract, however, a manufacturer could not be liable for breach of warranty, and any liability must be a matter of tort (breach of civil duty of one individual to another). Professor Prosser stated, "Why not, then, talk of the strict liability in tort . . . and discard the word 'warranty' with all its contract implications? The American Law Institute approved the proposal, and adopted, in the second Restatement of Torts, a new section, which states the strict liability without using 'warranty'."

According to Professor Prosser, the doctrine of "strict liability in tort" evolved in the courts in those cases of sales of products where, for want of a legal contract between the parties, there was no implied warranty:

The public interest in human safety requires the maximum possible protection for the user of the product, and those best able to afford it are the suppliers of the chattel. By placing their goods upon the market, the suppliers represent to the public that they are suitable and safe for use and by packaging, advertising and otherwise they do everything they can to induce the belief. The middleman is no more than a conduit, a mere mechanical device, through which the thing is to reach the ultimate user. The supplier has invited and solicited the use; and when it leads to disaster, he should not be permitted to avoid the responsibility by saying that he made no contract with the consumer, or that he used all reasonable care. It is already possible to enforce strict liability by a series of warranty actions, by the consumer against the retailer, who recovers from the distributor, and so on back to the manufacturer; but this is an expensive, time consuming and wasteful process. What is needed is a shortcut which makes any supplier in the chain liable directly to the user.

Professor Prosser, in commenting on "hepatitis" cases, stated in his article:

Finally, there are the cases of hepatitis resulting from blood transfusions. Most of them have denied the strict liability on the rather shaky ground that the transaction is a service, and not a sale of the blood, . . . [but there is] little room for doubt that the real objection to recovery is the inherently unsafe character of the thing supplied. All this leads rather irresistibly to the conclusion that there is no strict liability when the product is fit to be sold and reasonably safe for use, but it has inherent dangers that no human skill or knowledge has yet been able to eliminate.

Judge O'Donnell reviewed Professor Prosser's articles, and then commented as follows on the recent controversial Illinois case:

Plaintiff gets encouragement from *Cunningham*



*v. MacNeal Memorial Hospital*, 113 Ill. App. 2d 74, 251 N.E. 2d 733 (decided July 8, 1969), in which the Appellate Court of Illinois held that the complaint for damages as a result of becoming affected with hepatitis after receiving several transfusions of allegedly defective whole blood in a hospital did state a cause of action. The Appellate Court found itself bound by the decision of the Supreme Court of Illinois in *Suvada v. White Motor Company*, 322 Ill. 2d 612, 210 N.E. 2d 182 (1965), which held strict liability in tort upon the appellee on the action brought for a defective brake system on a tractor.

The Appellate Court, in the Cunningham decision, stated: "*Suvada* is a landmark case in Illinois law, . . . [because] the court openly laid down the rule that liability was based, *not on warranty*, but rather on *public policy*."

Significantly, Judge O'Donnell included Justice Burkes' judicial dissent to the Cunningham decision, which states in part, "Each of the cases which has sprung from the doctrine of strict tort liability has dealt with a commercially prepared for profit product. Blood, the essence of life, has come to us from Him who created that life . . ."

Judge O'Donnell then examined the status of the principle of "strict liability in tort" in the state of Maryland. He noted that the doctrine of "strict liability in tort" had twice recently come before the Maryland Court of Appeals and had been twice rejected as a basis for liability, and cited *Myers v. Montgomery Ward and Co.*, 253 Md. 282, (1969), in which the Court of Appeals stated in pages 296-7:

In this facet of the argument, Myers urges that we adopt the Rule of Restatement, *Torts* 2d (1965) §402A, which articulates the doctrine of strict liability irrespective of fault: . . . The same contention was urged on us in *Telak v. Maszczenski*, 248 Md. 476, 237 A. 2d 434 (1968), where we . . . declined to espouse the cause of strict liability at that time. Nor are we prepared to do so in this case.

Judge O'Donnell's concluding statement is worthy of extensive quotation:

Although the Plaintiff argues that "public policy dictates holding the hospital liable without fault," it is difficult to envision that our Court of Appeals would hold the Defendant "strictly liable" without fault, in view of its critical comments concerning §402A of the "Restatement." It is not

for the trial courts of the State to create or promulgate "public policy;" if, indeed, a pronouncement of public policy is necessary as a basis for liability of the Defendant, such policy pronouncement must be made by the Legislature or by the Court of Appeals.

If, as Professor Prosser suggests, "public policy" dictates that the "burden of losses consequent upon use of defective articles is to be borne by those who are in a position to either control the danger or make an equitable distribution of the losses when they do occur," on the stipulation filed herein by the parties that the defendant is a non-profit hospital, the reasons for the "equitable distribution of the losses" are here lacking. Indeed, the "risk distributing" theory would be inapplicable to a non-profit hospital since any loss could not be added to the "price of the product."

The professed attitude of the Maryland Court of Appeals concerning §402A of the "Restatement", the lack of a "sale" . . . and the fact that the Defendant is a non-profit hospital, as well as the fact—on the record submitted to the Court by stipulation—that the transfused whole blood appears to be an "unavoidably unsafe product", compels the Court to answer that there is no liability on the part of the Defendant, Johns Hopkins Hospital, to the Plaintiff by reason of strict liability without fault.

The Court ruled that the questions of law submitted must *each* be answered in the negative. The hospital was not found liable on the basis of negligence, breach of implied warranty, or strict liability in tort.

The significance of this case may be summarized as follows: First, it seems clear that when a test for the presence of hepatitis in donor blood becomes available and its use generally accepted, failure to use it may constitute cause for action in negligence. Secondly, the court held that blood transfusion is a service and not a sale, but even if it were a sale, the product is "unavoidably unsafe", and no warranty exists. Finally, the doctrine of strict liability in tort (that applied in Illinois case of *Cunningham vs. McNeal Memorial Hospital* was exhaustively examined and rejected, on the basis of prior appellate opinion.

A reasonable conclusion for those responsible for blood transfusion in the state of Maryland is that although not liable (today) as a result of implied warranty, or strictly in tort, they must make every attempt to exclude hepatitis.

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*The author would like to thank Mr. Michael Ventura, attorney for The Johns Hopkins Hospital, for his helpful comments during the preparation of this manuscript.*

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*New Maryland legislation, effective July 1, 1971, restricts liability from post-transfusion hepatitis to negligence, and excludes implied warranty and strict liability in tort as causes for liability.*



I cannot resist the temptation to tell about our first winter vacation, spent on a colorful but small—30 by 100 miles— island, only three hours away from home. At a total cost of about \$800, my wife and I “lived it up” for a brief seven days and six nights. Where? In Puerto Rico.

# Puerto Rico:

## Diary of a Summer Vacation in the Winter

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Puerto Rico was not our first choice. We had seen a lovely photo of Jamaica and liked the idea

of a Caribbean island with a nice view of mountains in the background. However, we ran into complications immediately. Everyone and his brother had the same idea for a vacation. Plane space was virtually nonexistent.

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At this point in our planning, we talked to Irving Ochs, the EENT man in our medical group, and its acknowledged world traveler. Without hesitation, he said, "Go to Puerto Rico." So, back to our travel girl and, sure enough, she could make the necessary arrangements without too much arm-twisting.

### Saturday, February 26

We left Baltimore's Friendship Airport at 11 AM on a brisk, breezy morning, with the temperature at a cool 38 degrees and bits of snow still clinging to the ground. We had the front seats and nearly froze to death before the take-off. The galley door was wide open while food and other supplies were being loaded. My wife sat next to the window. I have since found out that this is the "jitters" seat; whoever sits there develops more "anxiety neurosis" than the person on the aisle.

All announcements were bilingual and we noticed that the crew knew all the passengers' names. We took off and circled over Baltimore. We could pick out some of the better known landmarks easily. We flew over the Eastern Shore, between the Chesapeake and the Atlantic, a lovely area of farms, then over Delaware Bay to Cape May, New Jersey, our last point of land, and then we headed south. The cold winter sky was very bright and the air a bit bumpy at the higher levels. The ocean below us looked far from inviting. I read most of the trip and tried to get warm, but my wife kept staring nervously out the window, regretting her refusal of the preflight drink—"too early in the morning."

### Welcome to the Island

We arrived in San Juan ahead of schedule, because we had the wind going for us. From the air, we were already in love with the tiny island. The weather was great—a temperature of about 80 to 85 degrees and a slightly balmy wind of five to ten miles an hour. It stayed that way for the rest of our week there, with the exception of some rain on one or two mornings. I was aware of the heat almost immediately after we left the plane, as if some jet was warming up its engines and had parked too close to us. The heat was not unpleasant—it was downright welcome.

The *puertorriqueños* were all gathered around the arrival gates, and it was incongruous to see everyone wearing bright, gaudy, light-textured clothes at the end of February. But we became accustomed to the sight quickly and looked forward to blending in with the natives.

While waiting for our luggage, I picked up a copy of the local monthly tourist guidebook called *Que Pasa* (What's Going on in Puerto Rico). This little book told us where to go, what to see, how

much to pay, which bus goes where. It was our translator, and our general adviser for entertainment and business.

Enroute to the hotel we saw a billboard plastered with signs advocating the candidacy of someone running for district attorney back in New York—a long way (geographically) from home. When we reached the Americana, we were glad we had reservations. Our room was on the third floor, *not* ocean front. At first this was disappointing, but later we were pleased with the arrangement.

We were reluctant to change into summer-wear immediately, so we went, as we were, to the Kum-Kum room, a sort of semioutdoor bar made to look like a "native" hut. Jamaican boys were beating out calypso tunes, and doing it well, too.

We returned to our room, dressed in beach clothes, and went down to the hotel shops on the basement level. I made my first purchase: a large straw hat, a necessity for me because recently I had a basal cell epithelioma removed from my nose and would not relish having another one too soon. The hat was broad-brimmed, with a gaudy colored band. I nicknamed it my "*Jibaro*" (EE-bar-o), a name that is usually associated with the native Puerto Ricans who live in the hills and earn their living cutting cane, or in the pineapple fields. The men, *los jibaros*, are about the only Puerto Rican men who wear hats; the rest of them, especially those in the cities, would rather be seen dead than in a hat, we were told, particularly a broad-brimmed straw hat with a gaudy colored band.

We walked to the beach, and the ocean water was warm, probably around 75 degrees, and very calm. There is a barrier reef a few miles out which makes for a cove rather than an ocean beach. We enjoyed our first swim, trying to pace ourselves, being mindful that there were still six days ahead of us. We followed our ocean swim with a short dip in the hotel pool, and then sat on beach chairs to dry off under a huge Scotch pine tree. (We also sat under the baleful stare of the beach boy. We had tipped him a mere quarter, not learning until later that the going rate was a dollar.)

It seemed impossible to us then that we could have been swimming in the Atlantic Ocean in February, when we rarely could talk ourselves into that same Atlantic Ocean in Maryland, in the middle of July or August! We looked at each other, didn't say a word, and then began to laugh. This was to become a common, almost reflex-like response of ours for the rest of the week in Puerto Rico. I have seen this as a sort of giggling-response between two very young girls in the office many times, but it was new for us—as if we were sharing some big, funny inside-the-family joke. We'd do it in restaurants, clubs, buses, almost everywhere we went, and for no apparent reason. I'm no psychiatrist,



but I'd guess that we were reverting to the simple joys of childhood.

Our first supper was in the metropolitan part of San Juan. Since the Americana is near the airport, and both are in the Isla Verde section of San Juan, we hailed a cab, a ridiculously simple task as they are just about everywhere you turn and, if you are walking, they honk at you to see if you want to ride. We reached the "Top of the First," a restaurant on the 17th floor of the First National Bank Building, at about 6:30. We were the first to arrive and in time to see the help all lined up military style, with the head waiter giving them a grand review and lecture. The dining room filled quickly, as soon as it was opened, and nearly all were *americanos*. Summer suits, light cocktail dresses, minks flying every which way.

After dinner we decided to walk around a bit. The evening was still young and the streets were well lit, so we felt adventurous. In 20 or 25 minutes we returned to the hotel by cab and then sat in the lobby to begin our first session of "people-watching." We sit. We do not talk. We sit and watch, and watch still more. We blend in with the scene as much as possible—a day-old newspaper held resting in the lap is a useful cover. We make as little noise or motion as possible. Later, back in our room, or more likely in the hotel barroom, we compare notes and laugh it up. Some nights we classified people into guests, employees, outsiders, and outsiders pretending to be insiders. One night we watched women only and grouped them into wives, wives but no husbands here, wives with daughters out looking for a husband.

Our first night at the "people-watching game" was a Saturday, so the watching was superb. Everyone was arriving by cab and going either to the casino (gambling), or to the supper club (Maurice Chevalier) or to the Port of Call (The Treniers). Most of the *puertorriqueños* were going to the American show, most of the Americans to the Latin show. We went to bed at 1 AM, after a full day of fun on this beautiful island.

### Sunday, February 27

We slept late—for us—and didn't "rise and shine" until around 9:30. We had to get to Mass. The desk clerk told us that the nearest Catholic church was a few blocks down the road. The "few blocks" turned out to be eight or nine. We walked them, beneath the warm Caribbean sun, dressed in our finest and warmest Sunday go-to-church clothes, perspiring, and not knowing if it was acceptable to remove coats.

The city of San Juan is a full-time working city, and clothing and behavior are guided accordingly. It is only within the confines of the hotels and the

beaches that anything goes, as far as clothing is concerned. We got to Mass just in the nick of time. In front of us was a cute eight- or nine-month-old baby, with a suntanned nose and no shoes, not an unusual sight.

After Mass, we took a cab back to the hotel, ate a good, solid breakfast in the hotel dining room, and then went for a quick swim.

We were going sight-seeing and so we dressed up again after our swim and waited in the lobby for our driver to pick us up for a brief tour of the outer part of the island. A fine group of people went with us on the tour, which included a bit of the poorer sections of the city. I was prepared to see real poverty and was not too shocked or alarmed by it. Any physician who has gone to a big city medical school will have seen much of the same and so is already conditioned to it.

Our first stop was at a crossroads town where we saw fighting cocks and drank a "piña colada." It was very good, a mixture of rum, pineapple juice, syrup and ground coconut, and it cost about 75 cents. It became our answer for a quick lunch, for the rest of our stay, taking the place of a malted milk back home.

We drove up "El Yunque" (the anvil) a lush tropical rain forest. The trip was most interesting. We saw palms, coconuts, pineapples, all sorts of growth, and had to keep reminding ourselves: "This is February!" The cattle we saw along the way were Brahmin and the birds in the fields with the cattle were white. The birds looked like miniature crane or heron.

Our next stop was beautiful, curved Luquillo Beach, which is publicly maintained. It is finely landscaped, with facilities for picnicking, and excellent bathhouses. Small huts line the road leading to the beach's entrance. At any one of them, you may buy a number of different kinds of Puerto Rican foods and snacks, prepared on the spot by some of the local matrons. Cocos frios—iced local coconuts—are sold at some of these stands for 10 or 15 cents. The proprietor tops the coconut with a machete right before your eyes, and then you drink the coconut milk through a straw.

We saw some good-sized lizards on the beach skirting rapidly among the bushes, and were told that they keep the island reasonably free of insects.

Not far from Luquillo, we stopped in a little village called Río Grande, a typical old Spanish town with the plaza (or town square) where supposedly boys and girls walk around in the early evenings—in opposite directions! It was too early in the day for us to see this quaint custom.

Baseball is a pretty serious business in Puerto Rico and stadiums were everywhere. Later on, we saw a housing project. Prospective buyers were out in full force looking at the sample homes but we



did not stop to look. We were back in the hotel in the early evening for another quick swim in both ocean and pool.

For dinner, we strolled down the road to a small steak house. (I should point out that nearly all the places in San Juan are air-conditioned and a coat and sweater are essential accoutrements if you don't want to freeze to death.)

After dinner, walking back to the hotel, we could hear the native tree frogs singing in the night. No one I spoke to has ever seen these little things but, come evening, you can hear them almost everywhere. We were told they also keep down Puerto Rico's insect population.

The tropical moon and the big dipper seemed out of whack to me, as if they had been hung upside down, but I'm no expert. I only know that they don't look the same back home in Maryland.

We "people-watched" in the lobby for awhile, but Sunday evening business was pretty dull, and so we went on to the Manager's Welcome Party. Free drinks and snacks were served, and a pretty good marimba band featured some boys hitting steel drums. We finally got into bed at 1 AM—again!

#### Monday, February 28

We were up very early, about 7 AM, but refreshed and relaxed. It was a glorious day overhead, and probably the best one of our stay, with the temperature around 80 to 85 degrees, a light breeze, and almost no clouds. It was a perfect day for taking pictures, as we had planned to do. While we dressed, we listened to the radio.

We had the hotel dining room almost to ourselves because of the early hour, and so we chose a lovely spot with a good view of the ocean. My wife could watch one of the tiny tree lizards climb up a coconut tree, starting from the bottom and climbing to the very top. I had the sliced fresh pineapple. I liked it so much I had it for breakfast every day for the rest of our stay. One word about the food in Puerto Rico: it is good—and we both ate like pigs. *But*, we did not gain one ounce in weight. In fact, we lost weight. Why? Very simple—we were more active than usual; we walked and swam all the time.

After breakfast, we waited in the deserted hotel lobby for our driver to come and get us for the trip to Old San Juan. Our driver finally arrived. We picked up three other people for this tour. One was a businessman from Detroit, travelling on an expense account. He told us he had been driving around the eastern half of the island and that San Juan was not Puerto Rico—that there is a lot more to the island than the big city. We agreed. The other two were a British couple, with a real Cockney accent. They were taking two months to tour the British West Indies—Jamaica, and all the rest.

Enroute to our first stop, El Morro, the old fort which guarded the port centuries ago, our driver showed us the home of Pablo Casals, the famous cellist. It was a reasonably nice white house.

We spent about 45 minutes at El Morro, and there were some good chances to take photos. The thing I remember most about this fort is that there are 89 steps to the bottom of it. My wife and I walked down them, one by one, and of course had to climb back all 89 of them to rejoin our group. It was not as fatiguing as we thought it would be; perhaps all the previous days of walking and swimming were getting us back into good physical condition.

Old San Juan is very lovely and very Spanish, with fine old Spanish architecture and narrow streets.

Another interesting stop on our trip was at the University of Puerto Rico. Twenty-five thousand students attend this university and about 17,000 of them are girls. We had heard that the university is a center of some of the hottest "freedom-from-the-United States thinkers," but we were treated very cordially.

It was only noon when we returned to our hotel, so we quickly changed into our regulation uniform of the day, beachwear, and headed for our favorite spot under the pine trees. This time I made sure that I tipped the boy the prescribed amount. We walked along the beach and then swam out a way. When we came out of the water, we swam in the pool for about an hour. There were quite a few children in the pool and I enjoyed playing with them.

That night we really went all out for our evening meal. We dined at "*Le Pavillion*," the French restaurant in the hotel next to ours. It is a small room with only about six or eight tables, but very plush. The waiters and bus boys outnumber the customers. The food was on the gourmet side. My wife had veal scallopini and I had *camarones* (small red shrimp). The prices—WOW! The bill came to \$17.25 for the two of us, and only one daiquiri apiece.

#### Tuesday, March 1

It was my wife's birthday and, like all good doctor-husbands, I had not bought her a gift yet. While she was still asleep, I sneaked off down to the shops and bought her a charm to add to her bracelet—a small coconut tree in gold—to remind her of this island and our first winter vacation in a summer playland.

Because of my shopping spree, we reached the beach a little later than usual, about 10 o'clock. We had just settled ourselves in the chairs when a small brown *puertorriqueño* came over and asked us for a penny. He was cleanly dressed and didn't look too poverty-stricken, so we were at first flabbergasted,



and then amused. We asked him to sit and pose for a picture, which he did quickly and expertly. It was an old routine for this child. We gave him a dime for his troubles, and then, looking at each other, broke into our "winter vacation in Puerto Rico" giggle.

After our usual swim, we dressed and set out for Old San Juan, planning to go by bus—but there was talk of a strike and no buses were available. We had been looking forward to taking the bus and were disappointed to have to again resort to a cab. The downtown area was swarming with tourists, most of them were from the cruise ships and were afraid to leave the general confines of the area, lest their ship leave without them. We made a few purchases and then went on to see the waterfront section, the Catholic Cathedral, the tomb of Ponce de Leon, and the body of a saint, Pius the Fifth, I believe. Mostly, we strolled around the small city parks and watched the Puerto Ricans. They were all more than friendly, too. We finally rode in a bus—back to the hotel and were so glad that we did. There were a lot of school girls on the bus, all in uniform and all with their ear lobes pierced.

### Wednesday, March 2

After breakfast, I was surprised to hear my name called. Sure enough, it was a classmate of mine whom I hadn't seen for at least 15 years. I'll never know how he recognized me. He had his wife and his golf clubs with him, but mostly he had come for the gambling. After playing the game of Who-is-Still-Alive? and Who-is-Practicing-Where?, we all left for the swimming pool. There had been some sailboats for hire on the beach and I thought I'd finally found a sailing partner, but no—he hated sailing.

In the afternoon, while my wife rested, I took a bus ride to the end of Isla Verde to see the charter boats. I wandered around, watched some net fishermen, and took pictures. Then along came some Puerto Ricans and one of them wanted money. He really scared me. I thought I was about to be robbed. I told him I had no money, that I had left it all in my hotel. At this point, I saw the bus arriving, and made for it in a hurry. I then learned that the man was only a panhandler and all he wanted was a dime. It was funny, if not ridiculous, as I thought about it later, but it was the only time in my life that I had been panhandled by an adult. Everything would have been all right if only we had been able to speak the same language and understand each other.

This day was to have another scare for me, and it came right after we went into the ocean for our afternoon swim. I saw a greyish-white fish swimming near me. It had a long, funny nose. It was a friendly thing and it would move with me when I moved.

Then it took to swimming between my legs, and that's when I suddenly found out what it was—a baby *shark*! Well, I got out of there pretty quickly. A native girl told me: "The little sharks don't bite." I didn't care for this assurance, nor for swimming around with *any* shark, no matter how friendly and little.

After our ocean dip, we drank some piña colada, our instant meal, and watched the usual run of beach people. I am not an avid bikini watcher and that was the main attraction for the day. I did watch some of the little boys mooching pennies from other vacationers, and it was sort of heartless the rebuffing they received from some of the people.

We went to a native restaurant that evening, "Cecilia's Place." The food was really delicious. I had oysters on the half shell, and they were the tiniest things you ever did see. The main course was the "Jibaro Special"—chicken with rice and fried beans. Both of us ate until we were full, but again no weight gain; all that swimming and walking was burning off calories as fast as we pushed them in.

### Thursday, March 3

At this point of our vacation, our pace slowed down considerably. The weather remained superb, with temperatures of 75 or 80 degrees, very bright and sunny with just a few breezes every now and then. We did little that was new this day, mostly swimming, people-watching, eating and, believe it or not, a bit of reading.

### Friday, March 4

We finally decided to leave the confines of our glamorous, expensive playpen, the hotel and its close environs, to see what a bit of the island beyond looks like. We rented a Ford and started out for some of the spots we had seen briefly on Sunday.

No sooner did we hit the road than it began to rain. Down here, the rain comes suddenly and lasts but a few minutes. The natives seem to sense it and will run for shelter as soon as a few drops begin to fall. They will stay under cover because they are sure it will soon blow over, and it does. Driving is not too bad, although some of the secondary roads are a bit narrow. The distance is marked in kilometers, and this, plus the strange sights, makes driving on your own a bit confusing at first.

Our first major stop was El Conquistador, a mountaintop hotel on the northeast end of the island. The view from this spot was breathtaking. We were in time for a buffet lunch. We had an all fish dish because it was Friday. There must have been at least a dozen different varieties of the finny creatures and they were all delicious. I felt brave enough to try some of the squid. It was not too bad, tasting a bit like salted herring.



We got a little bit lost on our return journey, despite the fact that the island road system is fairly simple. Our trouble was that if we saw an interesting looking side road, we followed it for at least a mile or two, then perhaps we'd go into a third road. We were in no hurry to return, except that the intermittent rain interrupted our meanderings from time to time. Before we realized it, we'd put 100 miles on the car. Incidentally, car rentals are very plentiful and very competitive. It pays to shop around for the best deal before renting a car.

Later in the afternoon, I finally discovered a sailing partner. He was from New Jersey and, like me, was not exactly an expert sailor. But we had a pleasant hour under the stiff breezes following all the rain of the morning. Finally, I could say that the vacation was complete. I sailed a boat, a positive must for anyone from the glorious sailboating area of Annapolis, Maryland.

We dined on swordfish steak at "Mario's," a seafood restaurant near our hotel, and then spent a pleasant evening at the Carioca bar.

#### **Saturday, March 5**

This was our last day. We ate a fast breakfast, and then had a dip in the ocean, ending with an extra long swim in the pool. We packed our things and then sat in the lobby, waiting to leave for the airport. Ahead of us was to be a bumpy plane ride through foggy weather, back to a cold, windy airport with the temperature hovering around the freezing mark.

The scene at the airport was something special. There were a great many people around the various airline centers, plus a lot of pushing, talking, and general confusion. It was like Times Square in New York on New Year's Eve. We soon learned this was par for the course. Whenever one Puerto Rican departs from the airport, at least ten friends and ten relatives come along to say goodbye.

#### **Farewell to the Island**

On our last night at the hotel bar, our favorite bartender said to us, "Next time, bring your grand-

children." You can bet your last dramamine pill there will be a next time.

#### **Tips to Travelers**

Hotel prices run from a low of \$99 to a high of \$199 a week for two, ours—\$180.

The various tours—to the rain forest, the old city, the rum factories—cost about \$5 to \$7, and are well worth it.

Tipping is no different than in the U.S.A., and the money, of course, is U.S. currency. Puerto Rico is a commonwealth of the U.S.A. and no vaccination or passport is required for entrance.

Air transportation (from Baltimore) was \$221 each, first class, round trip.

All meals for the entire week cost us about \$80.

We took very little cash with us, and used the American Express credit card almost exclusively.

There is an old axiom that states: when traveling take half the clothes you think you'll need and twice the money. For Puerto Rico, this was not true at all. We brought almost no cash. As for clothes, about *one fourth* would have done nicely. It is very easy to advise what clothes *not* to bring—overcoats, topcoats, goulashes, gloves, long johns. Clothes to bring: light summerwear things, light dresses, slacks, light blouses, shirts, and, of course, bring two bathing suits—one for drying out, and one for swimming. If your wife has a mink or any other fur, by all means bring it along. If she has no mink, a medium weight sweater will do, because almost every place in Puerto Rico is air-conditioned. Men all wear jackets to dinner.

Shopping: we did very little, although it is all there for those who want it. Just about everyone buys some rum to take home. Another popular item is the hollowed out gourd that children use for making music.

Climate: May I repeat? It's superb. It's wonderful. We went to Puerto Rico primarily to enjoy this number one attraction, the wonderful climate. We were not disappointed. It is the closest to an ideal climate that you'll find anywhere in the world, we think.

**Make Plans Now to Attend  
Med-Chi's 1971 Semiannual  
Meeting in Puerto Rico  
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information and a reservation form**



# your medical faculty at work

by John Sargeant  
Executive Director

## **The Executive Committee met on Thursday, April 29, 1971, and took the following actions:**

1. Authorized spending up to \$500 from the Educational Fund for the Fifth Annual Seminar on the Medical Aspects of Sports;
2. Approved submitting the following names to the Secretary of Health and Mental Hygiene for selection of one as a member of the Commission on Medical Discipline:  
Charles Bagley, III, MD, Salisbury  
Aaron H. Traum, MD, Silver Spring  
Robert J. Thomas, MD, Frederick
3. Selected nominees to the Blue Shield for appointment to the Reference and Appeals Committee;
4. Authorized the Faculty President to designate the individuals who would meet with the Governor, should such a meeting be arranged, to discuss Comprehensive Health Planning procedures;
5. Approved the philosophy of participating in an interdisciplinary council which would review medical and related procedures in extended-care facilities, nursing homes, etc; and authorized the organization of such a council to be developed jointly by the Nursing Home Liaison Subcommittee and the Peer Review Committee;
6. Approved mailing a questionnaire to all members regarding Maryland Blue Shield and physician participation in the Blue Shield programs;
7. Approved the concept of the Metropolitan Baltimore Regional Planning Council's survey on Emergency Medical Services at hospitals in the area;
8. Authorized submitting the following list of names to the Governor for an appointment to the Commission on Kidney Disease, recently established by the General Assembly:  
Donald T. Lewers, MD, Baltimore  
Francis J. Borges, MD, Baltimore  
Robert I. Levy, MD, Baltimore
9. Temporarily deferred any action regarding a policy decision on the practice of a physician being required to view the body of a deceased

person before signing a death certificate;

10. Went on record as favoring the continuation of the Baltimore Criminal Justice Commission, whose funds have been deleted from the United Fund budget;
11. Heard a progress report concerning discussions on a site for a new Faculty building.

## **The Council met on Thursday, April 29, 1971, and took the following actions:**

1. Declined to accept an offer of membership on the Maryland Health Maintenance Committee until a copy of its bylaws, charter, and material outlining its objectives can be studied;
2. Received for information a proposed rate increase for professional liability insurance that the St. Paul Companies has filed with the State Insurance Commissioner;
3. Heard from Maryland Blue Shield, Inc., and approved mailing an information letter to all chiefs of staff and administrators of Maryland general hospitals, with a copy to component societies. The letter will outline the decision that Maryland Blue Shield, Inc. could not require private physician's test results to be accepted by hospitals and that any such arrangement was to be made by each individual hospital;
4. Adopted as Faculty policy the Current Procedural Terminology as published by AMA, and went on record as urging Maryland Blue Shield and other third-party payors to convert to this terminology as rapidly and efficiently as possible;
5. Designated the Executive Committee to act as liaison with the Comprehensive Health Planning Agency and to speak on behalf of the Council on any proposals scheduled to come before this state agency;
6. Heard a report from the Library Committee on the disposal of duplicates in its rare book collection;
7. Heard a report from the Legislative Committee on activity during the recent 1971 General Assembly session.



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DOUGLAS G. CARROLL, MD, EDITOR

## rehabilitation notes

This will be the last *Rehabilitation Notes* under the present editor. This department was started to emphasize the role of rehabilitation in medical care. The rehabilitation literature is rich in directions on how patients should be treated. However, there is little data on the results of treatment, nor can one tell whether the patient has improved as a result of rehabilitation techniques or as a result of the natural course of the disease. Thus, these columns have attempted to emphasize personal experience with treatment and concern with methods of measuring improvement.

The present column makes the 108th article published serially over the last 6½ years. The emphasis has been on the evaluation and treatment of patients with such chronic diseases as heart disease, arthritis, neurological diseases, paraplegia, as well as the problems of the elderly patient with "chronic brain syndrome" and hip fractures. Measurement of hand function and treatment of hand disabilities have been particular interests.

The articles were aimed more at the person in practice than at the specialist in physical medicine and rehabilitation.

There have been 19 contributors: five physiatrists, five orthopedists, two rheumatologists, one cardiologist, three internists, one psychiatrist, one neurosurgeon, and one neurologist. This wide interest in the field of rehabilitation emphasizes the major need to coordinate the different specialists to bring each particular specialist's knowledge to bear on an individual patient's problems. Most of the articles have contained some new information previously unpublished.

### Accomplishments in Rehabilitation in Maryland Since 1964

When *Rehabilitation Notes* was started, there were departments of physical medicine and rehabilitation in only four Baltimore hospitals. There were five board-certified physiatrists in the Baltimore area.

Since that time, six more hospitals have opened separate departments of rehabilitation, and the number of board-certified physiatrists has doubled.

A department of rehabilitation medicine has been established at the University of Maryland and a professor of rehabilitation has been appointed at The Johns Hopkins Hospital.

The curriculum in physical therapy at the University of Maryland School of Medicine has continued to produce increasing numbers of well trained physical therapists and has greatly improved the availability of physical therapists.

A school of certified occupational therapy assistants, originally started in Washington and transferred to the Keswick Home, has now been incorporated into the Baltimore Community College.

A new program for physical therapy assistants is developing at Baltimore Community College.

Vocational rehabilitation in Maryland has significantly increased its service to the handicapped of the state in many major areas. The effectiveness of the rehabilitation program in the United States is measured by the number of rehabilitations per 100,000 population. Using this yardstick as a measure, Maryland has advanced from 25th place in the nation in 1964, to 13th place in 1970. In 1966, 9,640 cases were being served, while in 1970, 21,862 were served. This significant increase has been largely due to the effect of PL-333 and the Maryland Governor's support of one of the most meaningful programs of the state. One of the many aims of the rehabilitation services in Maryland is to have an office within 25 miles of anyone in the state who can benefit. It is anticipated that this aim will be realized by the end of 1971. More than 15 cooperative-educational vocational rehabilitation programs have been developed in the 23 political subdivisions of the state.

Major programs have been developed for the public offender. Units are well established at the Maryland Correctional Training Center, as well as the large correctional facility in Baltimore city. These will be directed toward educational-release, work-release, and pre-release offenders. There is reason to believe that this program, in cooperation with the



correctional program of the state, will significantly enhance the opportunity for the public offender to reenter his community and be a contributing member of the state.

Major cooperative efforts have been made with many inner-city disciplines to reestablish individuals who are believed to be socially and culturally deprived. This is a very new program with the initial stages suggesting a favorable return for the investment.

Prior to December 31, 1971, it is hoped that Maryland will open the doors to its first comprehensive vocational rehabilitation center. It is built on the grounds of the Montebello State Hospital and is immediately adjacent to it. The cost is estimated to be approximately \$7,250,000, half of which will be met with state funds and the rest with federal funds. It will be operated by members of the Division of Vocational Rehabilitation. It will offer comprehensive evaluation: medical, psychological, social and vocational; counseling and planning with clients; coordination with field counselors; medical consultation and supervision; P.T. and O.T., speech and audiology, prosthetic appliances; adjustment services for the blind; 60 training courses in 28 training shops; personal and social adjustment training; staff training; research studies; and recreational activities.

Essentially, it will serve the severely disabled, particularly those with problems of mobility, also those needing a combination of services or special handling in the favorable climate of a comprehensive vocational rehabilitation center. The facility will accommodate 300 resident clients and 150 commuters.

A number of voluntary health organizations have improved the availability of paramedical personnel. The Crippled Children and Adults' program has helped to make speech therapists available throughout the state. The Maryland Arthritis Foundation has a Committee on Allied Health Professions. The Maryland Heart Association has been involved in rehabilitation of the patient with heart disease for over a decade.

The Instructive Visiting Nurses has continued to send public health nurses, physical therapists, and

occupational therapists into the homes of patients in an attempt to help them learn how to adjust and to improve their activities of daily living.

Medicare has made available, to those who have Part B, various braces and orthotic devices at a reduced price.

As for the future, rehabilitation medicine is in a unique position to provide leadership in developing new and more effective methods of delivering health services, because of its many years of experience in multidisciplinary health care. More emphasis now needs to be placed on ambulatory care at both ends of the health-care spectrum—prevention and rehabilitation.

But a mere listing of programs, personnel, and buildings does not tell the whole accomplishment of rehabilitation. The real story lies in the lives of individual patients: A sociopathic boy with a criminal record suffers a tragic high severance of the spinal cord. After a period of mourning, he becomes a new person with profound direction and purpose, marries and operates his own watch repair shop. A 45-year-old woman with severe destructive juvenile rheumatoid arthritis comes to the hospital with severe bilateral hip, knee, shoulder, elbow contractures, bilateral dislocation of the wrists with severe MP joint destruction. After a long series of operations, physical and occupational therapy, she masters wheelchair activities and is discharged to home, completely independent.

These pallid descriptions of the patient's medical course do not fully reveal the indomitable spirit which refuses to accept the past and insists on looking forward to the future with hope. Or one repeatedly sees the acceptance with dignity and strength, inevitable dependence, and even death.

And what of the physician? It must be an unfeeling person indeed who practices medicine and does not see beneath the turmoil, into the depths of at least some of his patients. He sees that in rehabilitation, the physician usually does not cure; he merely makes available to the patient tools, methods, and advice which the patient must use for his own cure. In rehabilitation, it is indeed the spirit which heals.

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MIRIAM L. COHEN, MD, EDITOR

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## the heart page

# Continuous Portable EKG Monitoring

MIRIAM L. COHEN, MD

Instructor in Cardiology

University of Maryland School of Medicine

Holter, in several publications between 1959 and 1961, described a portable EKG tape-monitoring system which is now being produced commercially. He vastly expanded the scope of electrocardiography, for the standard machine can only record at rest, for a small fraction of time, and usually not when the patient is symptomatic. Holter's system obviates these limitations. The required equipment consists of a 3½ lb battery unit which is worn in a shoulder case, and an electrocardioscanner which reviews tapes at 60 times normal speed. A bedside unit is available which can record an EKG for as long as 72 hours. The lead system used is equivalent to a  $V_4$  or  $V_5$ . During the monitored period, the patient keeps a careful diary of his activities and symptoms. A standard tape will run for ten hours and can be reviewed on the scanner in ten minutes. A synchronized clock is used to correlate EKG findings with the patient's activities, and abnormalities are documented on EKG paper at normal speeds.

EKG tape monitoring has been helpful in many clinical situations. Dizziness, syncope, or seizures may be secondary to labyrinthitis, cerebrovascular insufficiency, or a CNS lesion, but commonly an arrhythmia is the culprit. Walter, Reid, and Wenger performed ten-hour tape monitoring on 39 patients with these symptoms and discovered ten patients who had ar-

rythmias as the apparent cause. Specific therapy improved eight out of the ten patients.

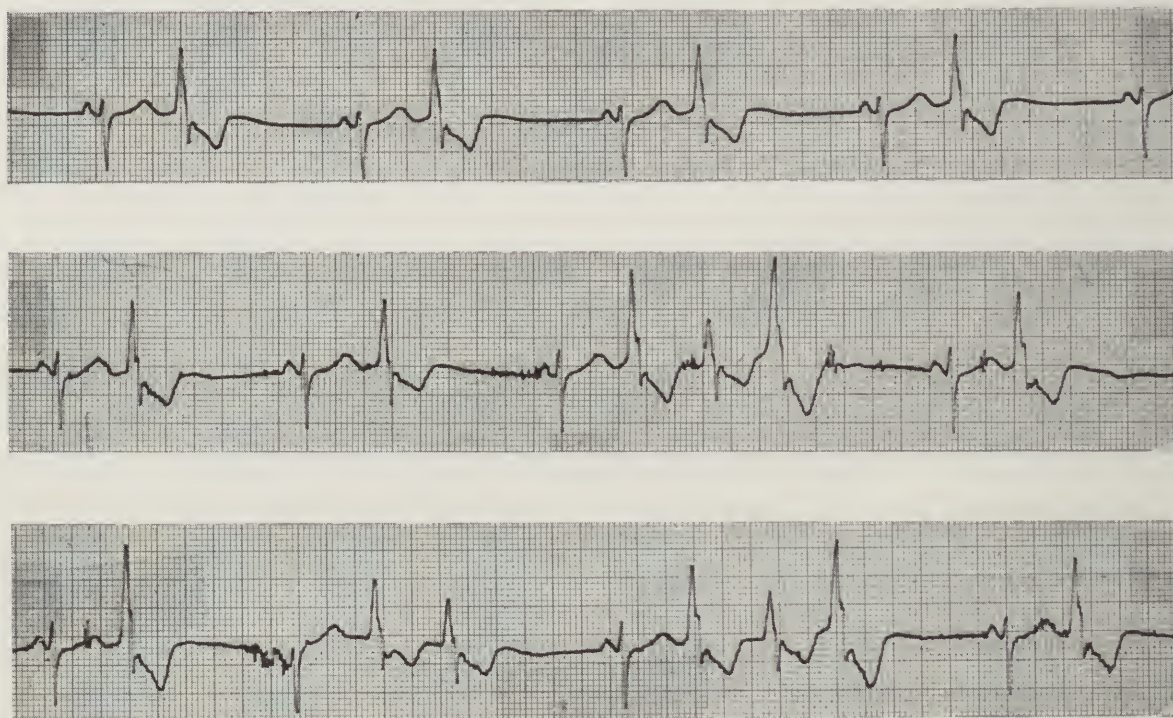
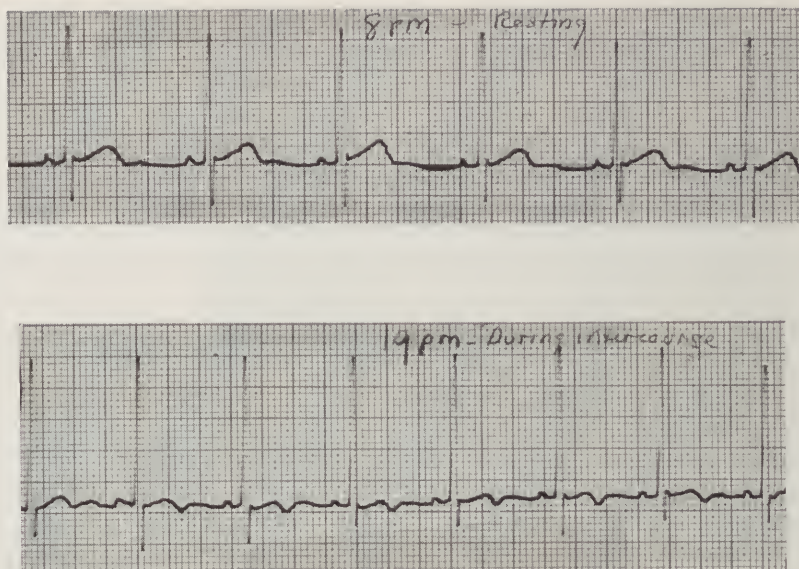
Patients with palpitations and a normal EKG may only have cardiac awareness, but an arrhythmia should be excluded. Portable monitoring often establishes the diagnosis, particularly if it is obtained coincident with the symptoms. Frequently, clues are found even if the patient is asymptomatic, eg, frequent PVC's, runs of PAC's, etc.

Chest pain may be related only to specific activities and standard exercise testing may be negative. However, tape monitoring may establish the presence of coronary insufficiency. An example is A. B., a 44-year-old man who had a history of chest pain with specific types of exertion with a resting EKG showing minor T changes. During sexual intercourse, he showed definite T inversion (see Figure 1).

Once an arrhythmia is diagnosed and the patient placed on specific therapy, portable monitoring may be valuable in assessing the effectiveness of the treatment. For example, D. V., a 45-year-old woman with frequent PVC's for at least three years, was very symptomatic, but usually would have no ectopic beats in her physician's office. Reserpine and propranolol were tried after other drugs had been used, and the patient was monitored. As Figure 2 shows, these were also ineffective.



**Figure 1: EKG of a patient showing minor T changes at rest (top) and definite T inversion during sexual intercourse (bottom)**



**Figure 2: EKG of a patient with frequent PVC's monitored at 2 AM during sleep (top), and at 4 PM when the patient was symptomatic (middle and bottom)**

The bedside EKG tape unit has been used to monitor acute myocardial infarctions. We have found that important transient rhythm disturbances may be overlooked by house staff and nurses in coronary-care units, mainly because it is impossible for personnel to constantly watch a monitor. Such a case was M. D., a 49-year-old woman who was taped during the first 24 hours after an acute M.I. Periods of sinus arrest

were not recognized clinically (Figure 3), but after the tape was reviewed, appropriate therapy was instituted.

Occasionally there is some question as to whether a patient with a known rhythm disturbance such as mild sinus bradycardia or junctional rhythms is a candidate for a permanent pacemaker. It may be difficult to correlate symptoms with the rhythm abnor-



mality unless prolonged monitoring is performed. Indeed, we have found several patients whose symptoms were unrelated to their arrhythmias—these individuals may not respond to artificial pacemakers. B. B., a 67-year-old woman, is an example. She had been complaining of “dizzy spells” for several months and was known to have periods of A-V dissociation

with nodal rhythm. Taping during a 12-hour period revealed NSR with 15 asymptomatic episodes of A-V dissociation and frequent PVC's with these episodes (Figure 4). A temporary transvenous pacemaker was inserted and left in place for three weeks with no alleviation of her dizziness. A permanent pacemaker was not inserted.

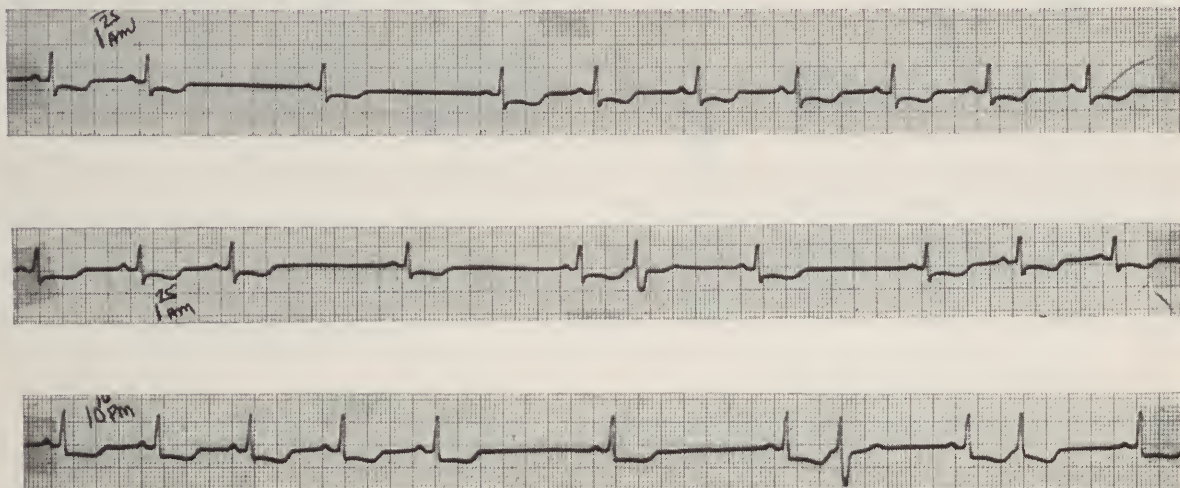


Figure 3: EKG of a patient taken 24 hours after an acute myocardial infarction—at 1:25 AM (top and middle) and at 10:10 PM (bottom)

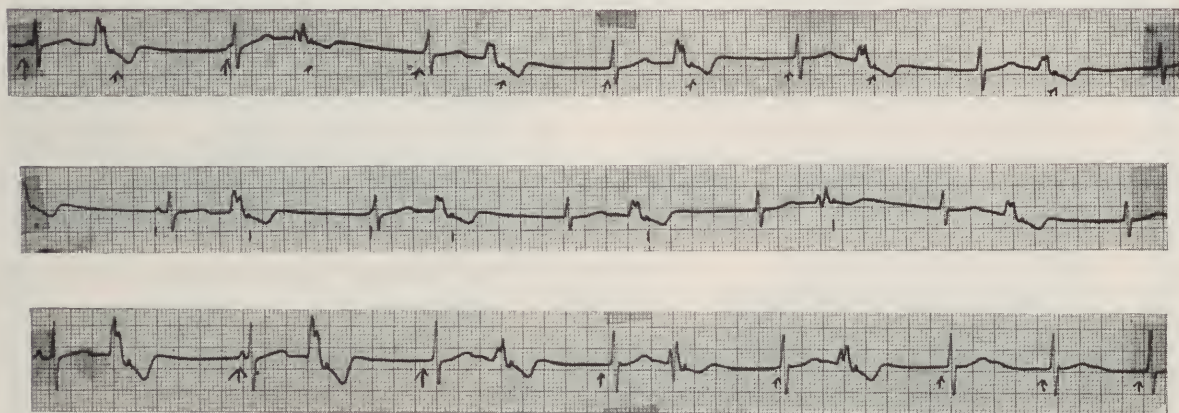


Figure 4: EKG of a patient with known periods of A-V dissociation with nodal rhythm. These were recorded during a 12-hour period.

Tape monitoring has been used to detect possible pacemaker malfunction in symptomatic patients with permanent units. It has also been valuable in diagnosing pacemaker competition in patients with fixed rate units.

Many studies have been published relating the variance in EKG findings on the tapes of normal individuals engaging in stressful activities such as para-

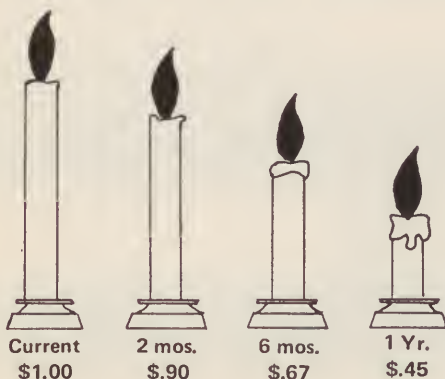
chuting, high altitude skiing, and mountain climbing. Indeed, probably one of the most valuable applications of portable monitoring is in recording active normal individuals, for then we will have a better concept of what is truly abnormal.

---

*References supplied upon request*



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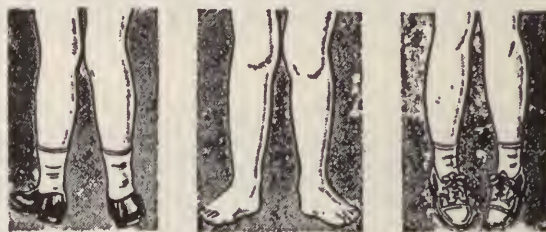
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# Conserving Electricity: A Guide for the Public

(The problems of producing and transmitting electricity, especially in the Eastern part of the United States, have reached the point where we must begin to conserve this resource. Not only will this permit us to cut down on the possible pollution from electric generating stations, but it will help to avoid voltage reductions and even power failures. The New York State Action for Clean Air Committee has prepared the following as a guide for the use of the public in this conservation endeavor.)

1. Which of your electrical appliances can you do without for awhile? For example, the electric can opener, the electric knife, perhaps the electric shaver. Which can you reduce in use?

2. Do not run air conditioning units when no one is in the office or home. Turn off such units a half hour or an hour before a room is going to be vacated. Do not use the highest settings for air conditioning equipment.

3. Use only lights which are necessary. If everyone saved the use of one 100 watt bulb a day, on a regular basis, for example, there would be little danger of power shortages.

4. Whenever possible, use appliances before 8 AM and after 6 PM. If there is a power reduction, major

appliances, such as freezers, refrigerators and stoves, should be unplugged, to prevent voltage irregularities from damaging the appliances.

5. Use dishwashers only once a day, preferably after the evening meal.

6. Keep radio and television sets in use only when someone is actually paying attention to the sight and sound.

7. Try to save some household chores for the weekends only, when electrical energy demand is lower.

8. Make sure the wiring and voltage in your home are of the kind needed to handle your electrical load. Homes which are poorly wired need more power in order to do a normal job of running equipment.

9. Make your own list of "don'ts" in your home and office, in order to conserve electricity. Get others to help in this conservation job, too.

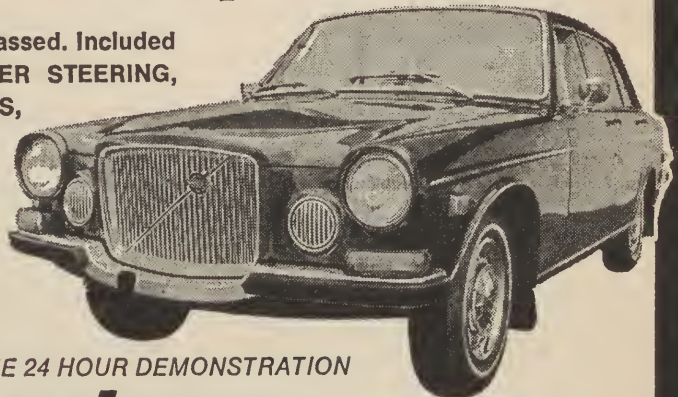
10. Urge your electric utility company to reduce its advertising which is designed to have consumers use electrical appliances.

11. Finally, if you follow this guide, you will not only conserve electricity and help reduce air pollution—you will be saving money, as well. And, it will be your money.

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She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

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Hydralazine maintains or increases renal blood flow.

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Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

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Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

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# Ser-Ap-Es<sup>®</sup>

reserpine 0.1 mg  
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## a plan for living with hypertension



# Ser-Ap-Es®

reserpine  
hydralazine hydrochloride  
hydrochlorothiazide

0.1 mg  
25 mg  
15 mg

**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy. **Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

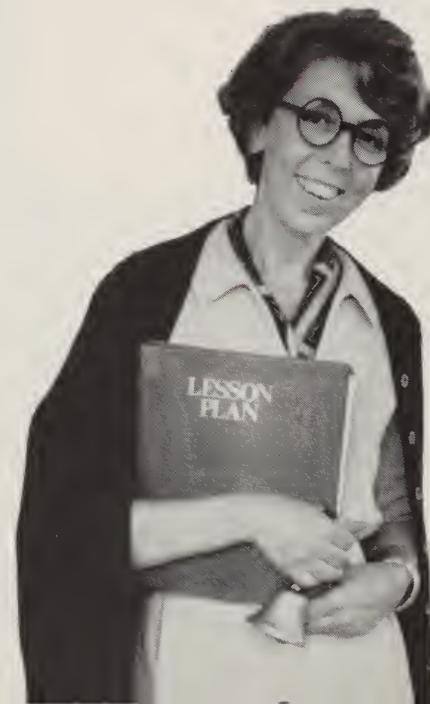
**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

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## tuberculosis

# Rifampin in the Treatment of Drug-Resistant TB

**Study of 30 patients with advanced cavitary TB shows that rifampin is extremely useful in retreatment programs in which it is combined with one or more effective antituberculosis drugs. Monotherapy courts failure.**

Rifampin, a semisynthetic, orally-administered derivative of rifamycin SV, has been found in clinical trials in the United States and Europe to be active against many microorganisms, including tubercle bacilli. The present report summarizes the results obtained from rifampin chemotherapy of 4- to 14-month duration in 30 patients with far-advanced multiple-drug-resistant cavitary tuberculosis. Most had multiple cavities ranging in size from 2 to 11 cm; average was 5.5 cm.

Under previous chemotherapeutic regimens, some of the 30 patients had cultures demonstrating resistance to as many as ten antituberculosis drugs. All but one were found to be resistant to at least three drugs. That one patient manifested multiple-drug allergies.

All had positive sputum cultures for *M. tuberculosis* within 30 days before or after the beginning of retreatment with rifampin. In each, rifampin sensitivity was demonstrated in vitro before therapy was begun.

The 30 TB patients were given 600-mg doses of rifampin daily. Initially, concomitant drug therapy

was limited to either isoniazid (INH), para-aminosalicylic acid (PAS), streptomycin, and ethambutol—or a combination of these drugs—even though no in vitro susceptibility to these drugs was demonstrable. Subsequently, as additional data became available, each patient received one or more drugs to which in vitro susceptibility had been demonstrated.

No patient received rifampin alone. However, 17 patients were given rifampin in conjunction with other drugs to which in vitro resistance had already been demonstrated in retreatment studies. These patients were considered to have received rifampin "monotherapy."

Sputum specimens were collected for culture and direct susceptibility tests on 7H11 agar medium at least once a week. Culture conversion was reckoned from the date the first of a series of negative sputum cultures was obtained.

Relapse was defined as the occurrence of a positive sputum culture after at least three months of consistently negative cultures. Positive cultures of patients under treatment were periodically subcultured on 7H11 medium containing concentrations of 1.0 $\mu$ g, 5.0 $\mu$ g, and 10.0 $\mu$ g of rifampin per ml to identify the emergence of resistance.

In the present series, pretreatment strains of *M. tuberculosis* were sensitive to 0.5 $\mu$ g of rifampin per

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*A. Vall-Spinosa, MD; William Lester, MD; Thomas Moulding, MD; Paul T. Davidson, MD; J. K. McClatchy, PhD. The New England Journal of Medicine, September 17, 1970 (Vol. 283, No. 12).*



ml in all but one patient. In that patient, tubercle bacilli were susceptible to 2.0 $\mu$ g.

No toxicity attributable to rifampin was noted in this series.

Twenty-one patients (70%) achieved quiescent status on retreatment with rifampin and remained so at the time of this report. The shortest duration of rifampin therapy producing sputum conversion was eight days; the longest, 90 days. Average was 40 days.

There were 13 patients who received concomitant chemotherapy with one or more antituberculosis drugs to which in vitro susceptibility was demonstrated in pretreatment cultures. Twelve of these patients (92%) had achieved and maintained negative-culture status. This group required an average of 33 days of combined chemotherapy for culture conversion.

This compares with the achievement of quiescent status in 11 (65%) of the 17 "monotherapy" patients who were resistant to all drugs except rifampin. To date, only two of these patients have relapsed, leaving an overall success rate of 9 out of 17 (53%).

There were nine treatment failures: eight among the "monotherapy" group and only one in the combined-therapy group. Seven patients failed to convert to negative cultures. The other two relapsed after 97 and 154 days, respectively. In both, the sputum cultures showed rifampin resistance from the date of relapse.

All failures demonstrated the "fall-and-rise" phenomenon, with colony and bacillary counts dropping at the start of therapy and then rising again as failure became evident.

#### Causes of Treatment Failure

Failures in this study were closely analyzed in an effort to determine the cause. Silicosis, broncho-pulmonary fistula, and empyema were notable adverse prognostic factors. High bacillary and colony counts, especially if associated with multiple-drug resistance, clearly appeared to predispose to failure. Such cases warrant most intensive chemotherapy and the utmost care in the selection of a regimen of maxi-

mum efficacy. This study reaffirms the finding that monotherapy courts a 50% rate of failure.

The results of this study, as well as all other reported trials, indicate that rifampin is a safe and very effective antituberculosis drug. However, its proper use is subject to the basic principle determining effective antituberculosis treatment. That is, no single agent can be expected to control cavitary pulmonary tuberculosis unless it is used in combination with one or more other effective drugs. Monotherapy appears to trigger bacterial resistance to the drug.

Therefore, the use of a single drug in patients with drug-resistant infection should be avoided whenever possible.

#### Concomitant Therapy

At the same time, the study indicates that the continued use of isoniazid or other antituberculosis drugs in the presence of demonstrable resistance is ineffectual. Therefore, it is strongly recommended that retreatment regimens include drugs that are demonstrably effective on in vitro studies.

Since no toxicity to rifampin was detected, it seems likely that it can be combined with other antituberculosis drugs without appreciable added risk. The combination of rifampin and isoniazid has been shown to be particularly effective. Thus, rifampin is emerging as another important drug for the management of patients who may require ambulatory chemotherapy on initial treatment. The potential availability of an oral ambulatory antituberculosis program based on isoniazid, ethambutol, and rifampin should effectively solve treatment problems in areas where hospital resources are unavailable. However, additional studies are needed to determine the mechanics of such a program. The high cost of rifampin remains a major problem.

The development of rifampin is a major advance in antituberculosis chemotherapy—especially in retreatment programs of drug-resistant patients. It should be evaluated most carefully and scientifically, however, lest it be squandered in ineffectual regimens, such as single-drug regimens which would trigger resistance to it.



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THE PHARMACOLOGICAL BASIS OF THERAPEUTICS  
3rd Edition, page 522



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Caution: Federal law prohibits  
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## PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

**DOSAGE:** One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

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**WARNING:** Do not give in advanced kidney or liver disease.

**PRECAUTIONS:** Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. **DOSAGE:** 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

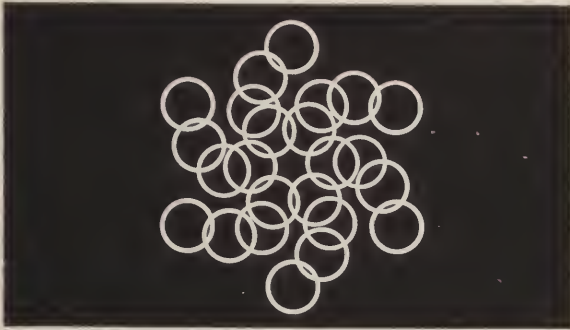
**NOTE:** The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.

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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# Attitudes and Skills of the Nurse in Working with the Alcoholic and His Family

**DOLORES QUEEN, RN**

Director of Nursing Service

Hidden Brook

Rehabilitation Center for Alcoholism

Bel Air, Maryland

The attitude of the nurse toward alcohol and alcoholism is an extremely important one for many reasons. For one thing, she is in a unique position as a member of one of the professions dealing with health. Even if she is not actively engaged in nursing, her family, friends, and neighbors never forget that she is a nurse. They will often come to her first for guidance and advice about a problem drinker, and she should at least be sufficiently informed about alcoholism to give them a few facts. She should also be able to refer them to community resources where they can receive further information and help. The nurse who is working in some field other than alcoholism should also be informed, for she will sometimes be involved unknowingly in the treatment of a person who is an alcoholic or who has been touched by it in his family. If the alcoholic is being treated for some other condition, she should be sensitive to its possible relation to alcoholism, to the nature of the early symptoms, and to those symptoms of alcohol withdrawal.

In working directly with the sick alcoholic, the nurse's skill during detoxification is greatly needed, just as much as if she were caring for the person with any acute, severe illness. The amount of nursing care and skill will vary with the degree and duration of the intoxicification. Simple intoxicification may require simple symptomatic measures; coma certainly constitutes a medical emergency. The presence and degree of complications such as convulsions and delirium tremens will, of course, affect the kind of nursing care needed, and a nurse, skilled at coping with any other medical condition, will also be adept in these situations.

The difference here is the attitude of the nurse toward the patient and his family, and the vital part this attitude can play in the motivation toward recovery. Her approach can sometimes be the turning point. By an understanding based on sound knowledge, she is in a unique position to help motivate and show the patient that someone does care and is in-

terested in him, and not only wants to, but is eager to help him.

The nurse should, before entering this type of work, look into herself, into her own attitudes and motives. First, she must have a factual knowledge of alcoholism and then, if she doesn't truly believe that it is a complex, insidious, progressive, fatal disease, it would be better for her to select some other field of endeavor. She must be able to come through to the alcoholic as a sincere, warm, friendly, and empathetic person.

Needless to say, a nurse who is a problem drinker herself should take care of her own problem first before attempting to help other alcoholics. It doesn't seem wise to hire a recovered alcoholic nurse, unless she has had two to three years of continuous sobriety, and not even then if she doesn't also have a sufficient degree of emotional stability. It is not necessary to be a teetotaler to work with alcoholics, as long as the nurse can accept alcohol as a social lubricant or



beverage for some people, as a ritual for others, and as a tranquilizing medication of sorts for the alcoholic, one which he can no longer use. In working with the alcoholic, a positive, hopeful, nonpreaching, accepting, and nonmoralistic attitude is essential.

It is important for the American nurse who works with foreign-born nurses and physicians to be aware of the cultural differences in attitudes. For example, a physician from India who has never seen an alcoholic in his own country may have little or no understanding of the problem. He may blame the alcoholic for his condition, and treat him in a chastising, punitive way. Here, the nurse might play the role of teacher if she can do it diplomatically, and if the foreign-born physician or nurse will accept it.

All traces of hostility and prejudice must be removed if the nurse is going to be effective. The alcoholic responds more to feelings than words and can sense an unfavorable or phony attitude immediately. In this way, they are much like children. "It is as if their nerve ends were extended way out from their bodies, probing for affection or rejection."<sup>1</sup>

The nurse must also remember that there may be times during the alcoholic's treatment when he will assign a role to her, which is not that of a nurse. This will be determined by his own past experiences, and this role may change from one situation to another. In one instance, he might consider the nurse to resemble the mother whom he loved, and in another situation, a feared and hated aunt. These concepts are formed on a completely unconscious level, but prompt the patient to respond to the nurse in the same way he responded as a child to the figures she represents. It takes a stable, mature nurse to deal with these experiences.

The alcoholic is usually a very sensitive person, and the nurse must have complete awareness of herself and the patient to deal with this properly. He will try to interpret any gesture, mannerism, inflection of voice, or imposing of restrictions as a personal affront or rejection. He is apt to "blast away" at the nurse for little or no reason. Going in the other direction, the alcoholic will sometimes build up strong emotional feelings toward the nurse, and will interpret any gesture of friendliness as a hint that she desires a more intimate relationship. This points up the need for the nurse to be consistent in all things, especially in the restrictions or limits she sets up, and to be sure that these restrictions are the same for all patients in the group.

The "patience of Job" is also a necessary ingredient. The alcoholic will make all kinds of unreasonable demands for medication, for special privileges, or for special attention of some kind. The nurse must be able to cope with these situations in a kind, but firm manner, remembering that most alcoholics will display a certain amount of immature

behavior. She must look behind the behavior and try to ascertain the feelings which prompted the behavior.

Another important skill is the ability to refuse a demand or request without causing the patient to feel rejected. This is not an easy thing to do, but if the nurse has a good, honest, and therapeutic relationship with the alcoholic he will accept her reasons, and his relationship with her, though maybe a little shaken, will not be damaged beyond repair. Also, she should always try to create an atmosphere free from shame, guilt, or fear, and safe from criticism or ridicule.

The nurse should also try to develop the attitude of an interested listener. The alcoholic will often test her, to see if she is truly interested. He will also try to manipulate her into telling him what to do. Regardless of what she feels would be the best course of action, she cannot yield to the temptation to be the "authoritative mother" and make his decisions for him. To do this would deprive him of the opportunity to use his own judgment and accept the subsequent consequences. Sometimes, just by listening, encouraging him to talk out his problem, helping him to see the alternatives, he can reach a rational decision, act on it, and gain self-confidence.

The nurse must also be aware of her limitations. She cannot be "all things to all men". She cannot sober a patient, or maintain sobriety once it is reached. She must be prepared to accept defeat and view the alcoholic's return to drinking, if and when he does (and many of them will) as a symptom of a relapse in a chronic illness. Just as she cannot consider a relapse a personal failure, so too, she cannot "swell up with pride" when a patient's treatment is successful or appears to be, and he maintains a comfortable sobriety. She must recognize her role as a "helper" in his treatment and know that the most she has done is to help him to gain insight, and then to help him to help himself.

The nurse who is happy and effective in this field will not necessarily possess all of these traits, but is motivated to try to develop them.

### Helping the Family Members

In many ways the same type of approach is used in dealing with the family members of the alcoholic. Recognizing that alcoholism is a family illness, she will realize that all of the family members have been affected by it. Because she is a nurse, her counsel will be sought and many misconceptions can be removed. She can be particularly helpful if the family members have no previous knowledge or insight about the illness. Awareness that alcoholism is an illness can be a comforting fact to a wife who has blamed herself for everything that is wrong in an



alcoholic marriage. She may have been shielding, protecting, and covering up the problem because of shame. The best role for the nurse at the beginning of the alcoholics treatment seems to be that of a good listener to the family. She should give them, especially the spouse, a chance to vent their anger and hostility (almost always present) and all other negative feelings, so that positive feelings can then emerge. The role of educator can come a little later. She should be warm, friendly, and reassuring, without being overly sympathetic or protective. She must never play the role of arbitrator between the alcoholic and his spouse, since one will always try to project all the blame on the other. Recognizing

that the children in an alcoholic marriage have also suffered emotionally, she must know the community resources and be ready to refer the spouse and children for therapy when it seems appropriate. When the spouse has been helped to see her own conflicts and needs which she either brought to the marriage or developed as a result of living with the alcoholic, she will be better able to give the family the stability it needs and to create the kind of home atmosphere needed by the alcoholic in his adjustment to sobriety.

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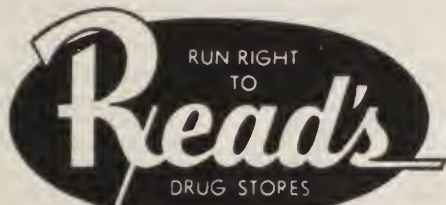
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## Letter to the Editor

The following letter was recently directed to all physicians at Baltimore City Hospitals by Edmund G. Beacham, MD, Chief of the Division of Chronic Medical Care at the hospital. It concerns the clarity of physician's orders, and was approved by the Pharmacy Committee and Joseph Bianchine, MD, Chairman of the committee.

Written "Doctor's Orders" are the means of communication between physicians and nurses to describe a specific treatment for a specific patient for a specific time and duration. My observation over 30 years of medical practice is that "Doctor's Orders" need much more physician attention than is commonly accorded this vital message. At the risk of oversimplification, I am suggesting three areas of consideration for our physicians.

(1) **Write legibly**—orders that cannot be interpreted because of physician's handwriting are frequent. Many nurses may have to read the same order sheet and all must be able to understand what has been written. The preferable procedure is to have a nurse read the order in your presence to be certain that she understands what is to be done.

(2) **Avoid abbreviations**—many abbreviations are easily understood and are accepted practice. Other abbreviations are not widely known or are open to misinterpretation, or both. I particularly object to Latin usage in abbreviations. Latin is being used less and less in general and premedical education. Nurses have little knowledge of what Latin terms mean except by memorizing their relation to English terms. Examples are: "before or after meals" instead of **a.c.** (ante cibum) or **p.c.** (post cibum); "bed-time" or at a specific time at night instead of **h.s.** (hora somni); "every day", "every other day", "four times a day" instead of the easily misinterpreted **q.d.**, **q.o.d.**, **q.i.d.**; "twice daily" or "three times daily" instead of **b.d.** (bis in die) and **t.i.d.**; **p.r.n.** (pro re nata) is well known but "as necessary" or "as required" is preferable; "with" and "without" creates less confusion than **c** (cum) and **s** (sine); even "right eye" and "left eye" is more understandable than **O.D.** and **O.S.**

If abbreviations are to be used, a list of accepted abbreviations and their meaning should be at hand when nurses must read orders.

(3) **Be more specific**—be certain that dosage is clear—how much, at what time, for how long! Special methods for giving drugs or treatments must be described in detail. I am suggesting that the Pharmacy Committee and Nursing Department review their role in "Doctor's Orders". Certain orders as "twice daily" or "three times daily" may mean different things to different nurses or departments. Many "three times daily" drugs are given at meal-times and if the physicians want drugs given every eight hours, this should be stated. "Twice daily" drugs may be given at less than eight hour intervals and if the physician wants them given at 12-hour intervals, he should state this.

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# Special Library Services for the Physically Handicapped

From time to time, this page will feature articles on major special libraries in the area. This month, the featured library service is "The Library for the Physically Handicapped." Their varied facilities and equipment for assisting handicapped people renders this a vital service to the community and to many, is relatively unfamiliar. Mr. James Murray is the director, Mr. James C. Partridge, Jr. the assistant director.

The Library for the Physically Handicapped directly serves the public and other agencies in the state of Maryland, and provides talking books (record and cassette), large-print books, and reel-tape materials for eligible users under Title IV-B of the Library Services and Construction Act. Individual patrons and local agencies throughout the state depend on this library for their reading matter. Patrons include the blind or visually impaired, as well as those who, for physical reasons, are unable to use conventional printed material.

The library staff circulates materials to patrons through mail or walk-in service, and provides depository collections to public libraries, hospitals, and nursing homes upon request. They select materials for individual patrons based on the reader's past reading interest, reading level, and current tastes. Periodical and special request service is provided, and the library answers many requests through recordings of specific material provided by a corps of over 30 volunteer readers. Equipment for playing talking books is provided by the library through the same free postage mail system. All

talking book materials in the library are supplied by the Library of Congress.

The library staff participates in workshops, and contributes to hospital programs and programs of other agencies where their services are needed. They work to promote their belief that library services should be as available to the blind and physically handicapped as they are other residents of the state.

Although most patrons of this library use the mail service, the facility draws a number of city residents. A ramp provides easy access to the building for those who cannot navigate stairs, and a floor runner serves as a directional guide for the blind or visually handicapped patrons of the library.

The Library for the Physically Handicapped is located at 1715 North Charles Street, Baltimore, Maryland, and welcomes its readers to visit the library. It is open Monday through Friday, 8:30 AM to 4:30 PM. If you have any questions, you may write to the library or call area code (301) 383-3111.

James C. Partridge, Jr.  
Assistant Director



### Lost Books

The following books were lost during the Annual Meeting at the Civic Center:

*Estimating space needs and costs in general hospital construction*, by James J. Souder.

*The history of the Negro in medicine*, by Herbert M. Morais.

If located, please return to the Med-Chi Library.

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## NEW ACCESSIONS—BOOKS

(Arranged by Subject)

### ANATOMY

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### CANCER

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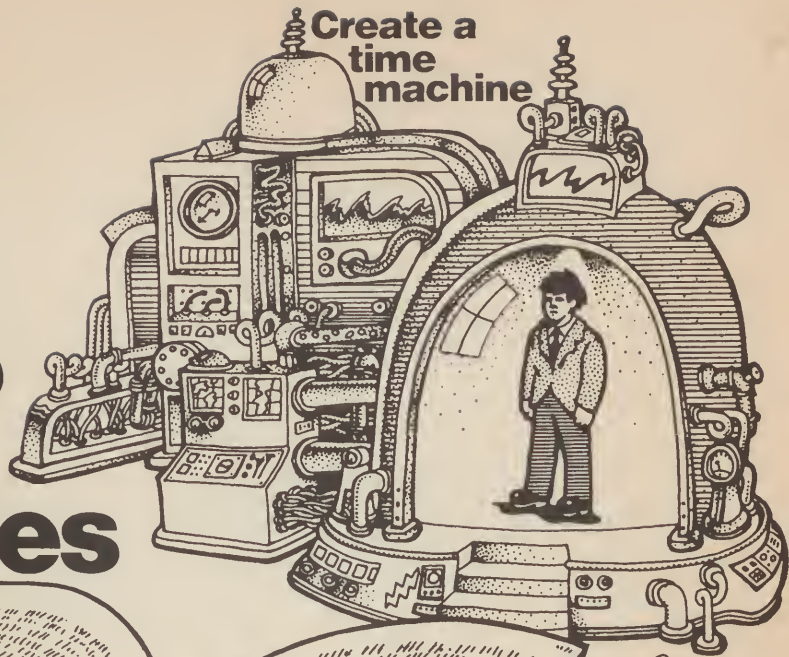
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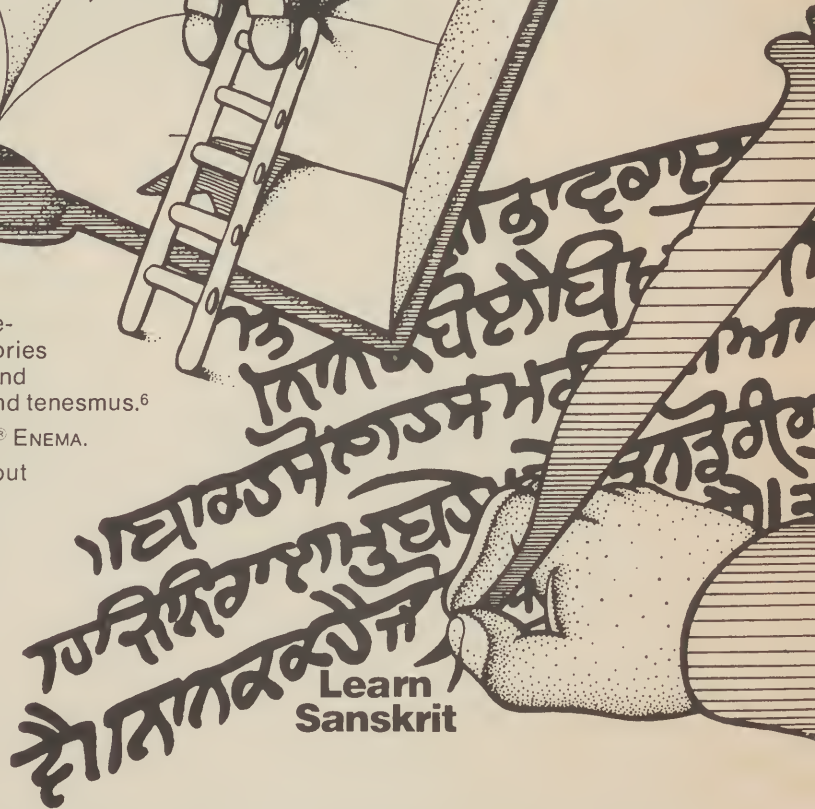
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cream/solution

## In the treatment of solar/actinic keratoses—

## An alternative to cold, fire and steel

2/23/68

Before treatment with 5% 5-FU cream.  
Patient R. G., 78 years old, shows  
extensive skin changes due to weathering  
and severe solar/actinic keratoses.

3/26/68

Following one month of therapy. Intense  
erythematous reaction is seen at sites of  
keratoses. Normal skin has not reacted.  
Some areas which had reacted initially  
have undergone healing despite continued  
topical application of 5% 5-FU.

6/11/68

Ten weeks after discontinuance of  
therapy. All areas have healed completely.  
Residual mild erythema remains in some  
areas. This patient also had seborrheic  
keratoses which, as expected, have not  
reacted. There is no evidence of residual  
lesions or recurrences.







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## An alternative to conventional therapy

Efudex (fluorouracil) offers the physician a topical alternative to cryosurgery, electrodesiccation and cold-knife surgery in the treatment of solar/actinic keratoses. It is effective, comparatively inexpensive and especially well suited for treatment of these multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.\*

## Highly effective

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When new lesions appeared, repeated courses of Efudex therapy proved effective.\*

## Predictable therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three months before gradually receding. Since this response is so predictable, lesions which do not respond should be biopsied.

## Two strengths—two dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings

and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



new  
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(fluorouracil)  
cream/solution

\*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.





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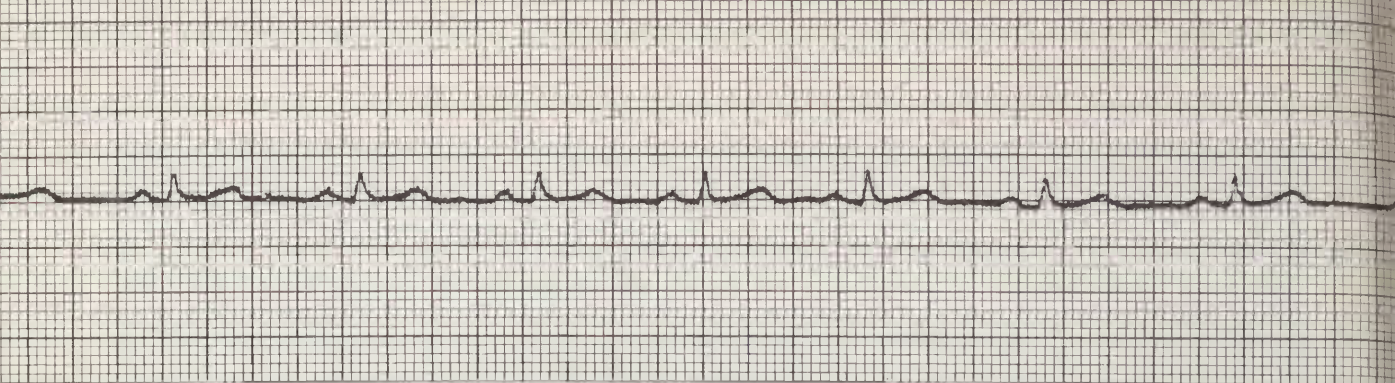


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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other

antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium<sup>®</sup> (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose<sup>™</sup>, packages of 1000.

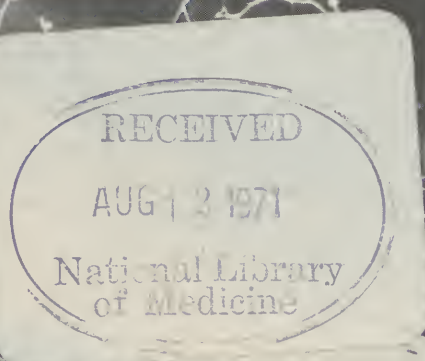
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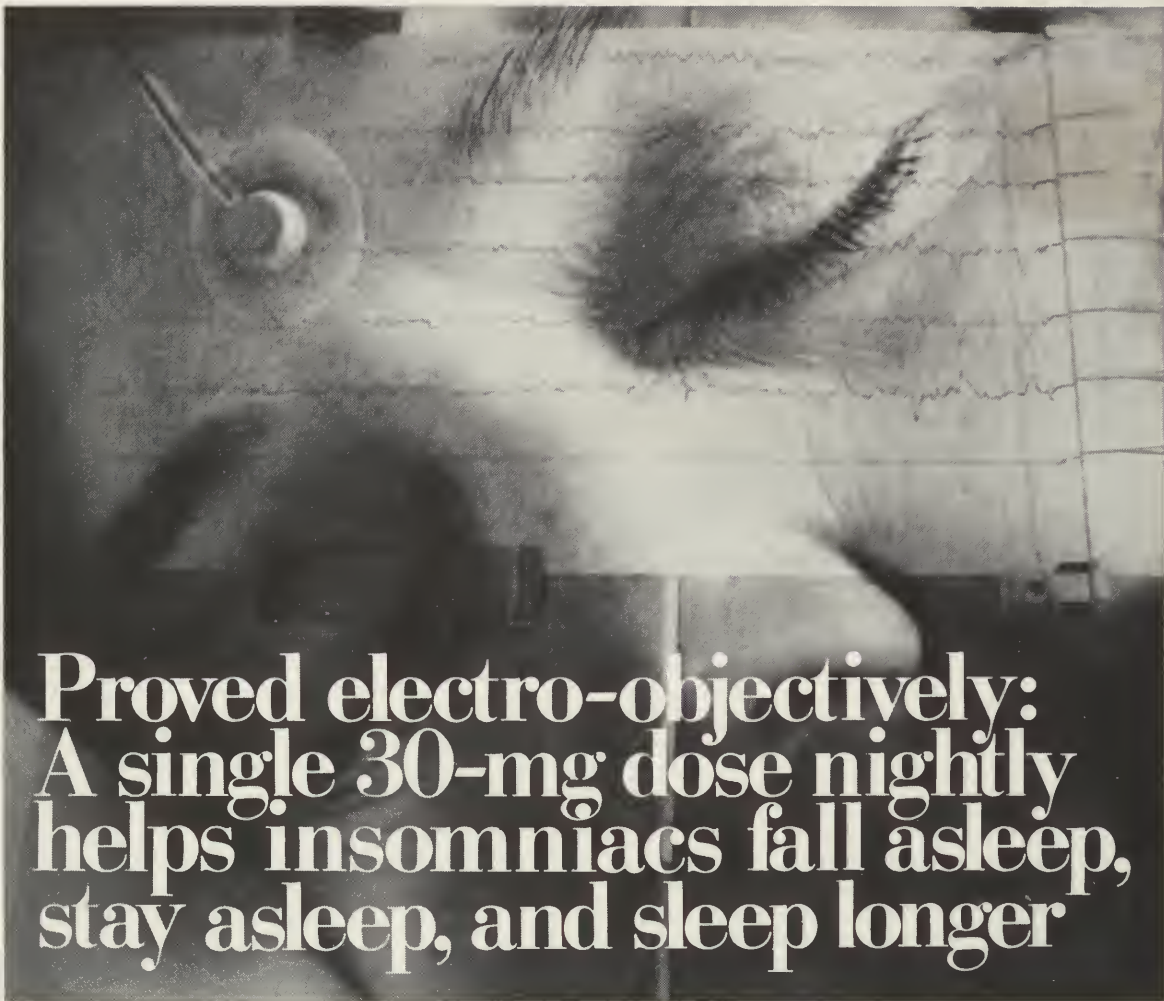
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# Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.<sup>1,2,3</sup>

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,<sup>1</sup> Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

---

## Confirmed clinically

---

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.



In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

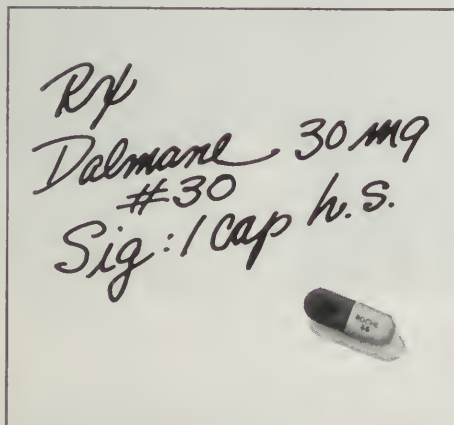
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### Dalmane (flurazepam HCl) is generally well tolerated

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In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.<sup>3</sup> Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

**References:** 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane**<sup>®</sup>  
(flurazepam hydrochloride)

### Before prescribing, please consult Complete Product Information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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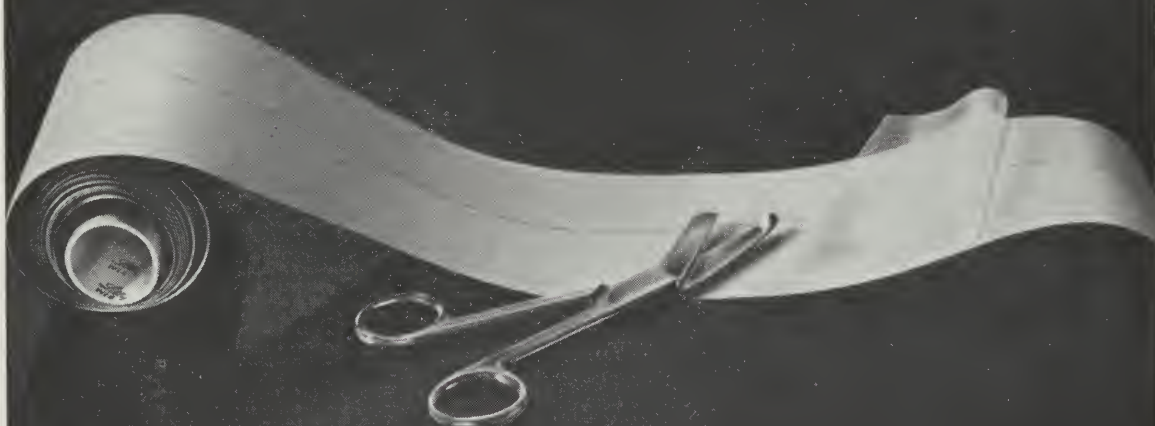
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Second Annual Seminar in General Surgery: Colby College, Waterville, Maine. The seminar will discuss areas of management of trauma, vascular disease, breast disease, and problems of the biliary tract. For further information, write: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.

## **JULY 26-28, 1971 HEART ASSOCIATION OF MARYLAND**

Meeting and Discussion—Three Days of Cardiology: "Clinical Decisions in Cardiology: The Patient with Coronary Artery Disease": Empress Hotel, Victoria, British Columbia. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

## **JULY 26-29, 1971 AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Recent Advances in Rheumatic Diseases: Stanley Hotel, Estes Park, Colorado. Co-sponsor is the University of Colorado Medical Center in Denver. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

## **JULY 26-AUGUST 5, 1971 AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Symposium on Research in Deoxyribonucleic Acid (DNA) Replication: Aspen, Colorado. Contact: School of Medicine, Washington University, 660 South Euclid Avenue, St. Louis, Missouri 63110.

## **AUGUST 29-30, 1971 AMERICAN MEDICAL ASSOCIATION**

31st Annual Congress on Occupational Health: Jackson Lake Lodge, Grand Teton National Park, Wyoming. Write: Louis R. Skiera, Assistant Director, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

## **SEPTEMBER 14-18, 1971 AMERICAN ASSOCIATION OF MEDICAL CLINICS**

22nd Annual Meeting: Sheraton-Cleveland Hotel, Cleveland, Ohio. Prepaid medical care, health maintenance organizations, financing of health services, and training and use of allied health personnel will be the featured topics. Problem-solving workshops will cover such problems as clinic quality control, cost effectiveness, multiphasic screening, physician recruitment, computer use in clinics, satellite clinics, education programs, and income distribution. Contact: AAMC, 719 Prince St., Alexandria, Virginia 22313.



**SEPTEMBER 18 AND 25, 1971**

**COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY**

Continuing Education Course—The Shoulder: A Course in Depth: College of Medicine and Dentistry of New Jersey, Newark, New Jersey. The course will deal with disorders of the shoulder. For further information, call Armund E. Foley, Director of Communications, at 201-877-4560.

**OCTOBER 13-15, 1971**

**DEPARTMENT OF DERMATOLOGY, NEW YORK UNIVERSITY SCHOOL OF MEDICINE**

Symposium—Allergic Eczematous Contact Sensitization: Alumni Hall, New York University Medical Center, 550 First Ave., New York city. Merrill W. Chase, MD, will speak on "The Mechanism of Contact Allergy and the Concept of Peripheral Sensitization." For further information, write: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N. Y. 10016.

**OCTOBER 30, 1971**

**MARYLAND-D. C. SOCIETY OF ANESTHESIOLOGISTS**

Symposium—Respiratory Insufficiency: Friendship International Hotel, Friendship Airport, Baltimore, Maryland. Clinical discussions of great current interest will include oxygen toxicity, postoperative pulmonary edema, lung mechanics, and respiratory failure. The registration fee is \$20, and includes lunch. Contact: Gerald J. Carroll, 5813 Meadowood Road, Baltimore, Md. 21212.

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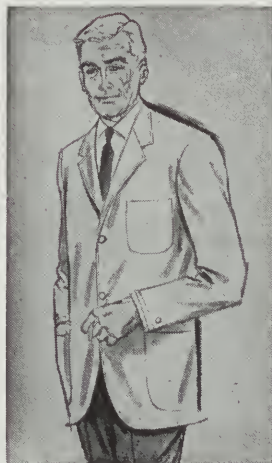
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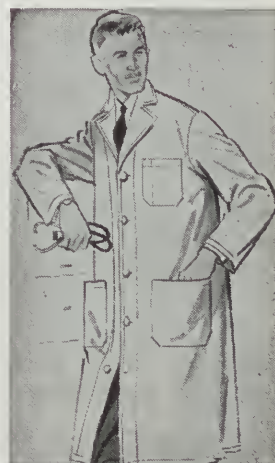
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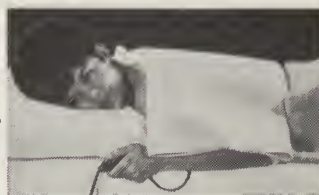
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# executive director's newsletter

July 1971

## RESOLUTIONS DATE

In accordance with Article XI, Section 24, the deadline for receiving resolutions for the Semiannual Meeting is Saturday, July 17, 1971. The Seimiannual House of Delegates session is scheduled for Saturday, September 11, 1971, in the Faculty building.

Following the business session of the House, the scientific meeting will be held at the El Conquistador Hotel in Puerto Rico. The total cost, including air fare (via Eastern Airlines 747), hotel room, meals, and gratutities is \$250 a person.

Reservations should be made through Mrs. Beverly Wolins at the Travel Guide Agency, telephone 727-1696.

## NEW LAWS EFFECTIVE JULY 1

New laws that take effect on July 1, 1971, and which affect physicians in Maryland include:

### 1. Broadening of the parental consent legislation:

In addition to the present statute that provides for treatment of minors without parental consent for venereal disease and pregnancy or suspected pregnancy, this statute has been broadened so that minors can be treated if any of the following apply:

- (a) Have reached the age of 18
- (b) Are married or are the parent of a child
- (c) Seek information on contraception, not including sterilization
- (d) Seek information regarding drug abuse
- (e) In the judgment of a physician the obtaining of consent would result in such delay as would adversely affect the life or health of the minor.

In all cases, the decision rests with the physician in regard to advising the parent or guardian.

### 2. Requiring every physician to indicate on his bill the amount paid to a laboratory for tests for which the physician is billing the patient. In addition, the name of the laboratory that performed the test must also be named. A physician



may now have disciplinary action taken against his license for failing to comply.

3. Lowering the age from 18 to 16 when an individual may seek diagnosis and treatment for mental conditions without parental consent.
4. Providing that a physician (and others) must report to local law enforcement authorities incidents indicating a gunshot wound that come to their attention.
5. Providing that all prescription labels contain the strength and name of the medication, unless the physician indicates otherwise.

NEW LAWS  
EFFECTIVE  
JULY 1  
(cont'd)

The Bureau of Narcotics and Dangerous Drugs requires that a new federal identification number be used effective July 29, 1971 on all drug prescriptions. Drugs are now categorized into classes I through V. In practice, almost all physicians need an ID number for all of these classes of drugs.

If you have not already applied for your new number, contact the Faculty office for further information.

Physicians are cautioned about signing "Prior Consent Forms" without carefully evaluating their legal implications. It is understood that some pharmacists have requested blanket authorizations from physicians that would permit them to make substitution on prescriptions written by physicians.

Faculty legal counsel advises against any such approval being given.

Law enforcement officials have brought to the Faculty attention the fact that stolen prescription blanks are being used by drug addicts to obtain illegal narcotics.

All physicians are cautioned to keep such blanks under lock and key. While the majority of such forged blanks have had hospital names on them, there are still a number from private physicians.

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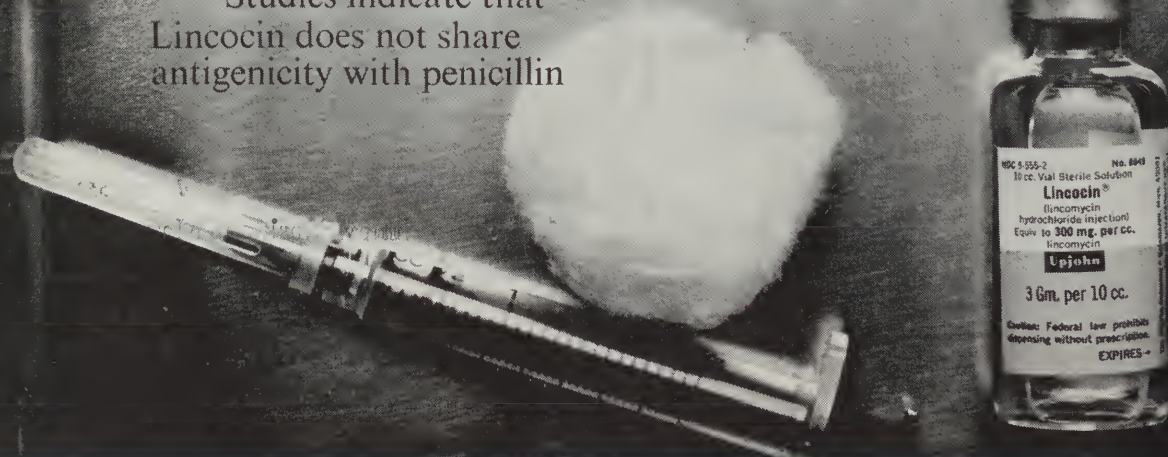


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Lincocin (lincomycin hydrochloride, Upjohn) has produced a high percentage of satisfactory responses in patients with mild, moderate and severe infections due to susceptible streptococci, pneumococci and staphylococci (including many penicillinase-producing strains). With  $\beta$ -hemolytic streptococcal infections, treatment should continue for at least 10 days.

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compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.





# So is penicillin-resistant staph.

Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with

all antibiotics, susceptibility studies should be performed.

Intramuscular and intravenous injections of Lincocin (lincomycin hydrochloride, Upjohn) are generally well tolerated. Instances of hypotension following parenteral administration have been reported, particularly after too rapid intravenous administration.

## **Lincocin<sup>®</sup>** (lincomycin hydrochloride, Upjohn)

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An antibiotic chemically distinct from others available, indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed.

**CONTRAINDICATIONS:** History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or

significant allergies. Overgrowth of non-susceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angio-neurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.

**Cardiovascular**—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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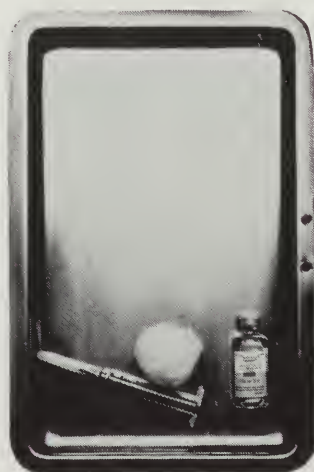
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ARTHUR E. COCCO, MD  
Journal Representative

## Baltimore City Medical Society

The Board of Directors met on the second Tuesday of May. After adopting the minutes of the April 13 meeting, the Board turned its attention to the forthcoming meeting of the Med-Chi House of Delegates. The Bylaws of the Society require that the Board of Directors review the items to be brought before the House at its meetings and make recommendations to the Delegates from Baltimore city.

The recommendations of the Board regarding the resolutions which were to be discussed were as follows:

Resolution 1A/71—Urging the employment of a professional negotiator. The Board agreed with the recommendation of the Med-Chi Reference Committee that this matter should receive further study from the Med-Chi Policy and Planning Committee.

Resolution 2A/71—Urging the formation and financing of home care service programs. This resolution was submitted by the Baltimore City Medical Society and the Board recommended its adoption.

Resolution 3A/71—Urging improvement of family practice programs at the medical schools. The Board recommended that this be adopted.

The Board felt that on the question of raising the Med-Chi dues, each delegate should vote his own mind and no recommendation would be made by the Board. With reference to the Bylaws which divides the present Committee on Postgraduate Education, Preventive Medicine and Public Health into two separate committees—one dealing with continuing education and the other with preventive medicine and public health—the Board felt that there would certainly be no objection to such a change.

The President left the meeting at this time and met with the delegates to present the views of the Board. In accordance with the recommendation of the Board that he suggest to the Delegates that although there was no opposition to the raising of the dues, the point should be made that the words "private practice" as used in this section of the Bylaws is unclear and the Bylaws Committee should be asked to reword the section or define "private practice."

In the absence of the President, the Board heard a report from the Chairman of the Finance Committee, Richard London, MD, and took the following actions: Deferred action on a recommendation that

the Society disconnect itself from the Med-Chi switchboard and install separate lines into the Society office with an answering device until further information could be obtained as to relative costs; approved a recommendation that a full-time secretary-bookkeeper be employed in the City Society office to replace the present part-time employee; approved a recommendation that the Bylaws committee be requested to draw up an amendment to increase the dues from \$25 to \$45.

By this time the President had returned to the meeting and resumed the chair.

The Board voted to waive the dues of a member of the Society due to illness.

Phillip Wagley, MD, then presented a report from the Scholarship Committee which was formed by the public school system to make recommendations for the recipient of the scholarship fund which was set up last fall. After some discussion, it was agreed to give the grant to Andre W. Poe, a student from Northern High School who ranked first among the 17 names submitted.

On May 1, Dr. Wagley met with the presidents of the York, Harrisburg, Philadelphia, and Washington, D.C. medical societies for the purpose of exchanging ideas. His reaction to the meeting was most favorable and he presented the following report to the Board:

Washington, D.C. has 1,600 active members and 800 associate members of whom approximately 500 to 600 are actively involved in Society activities. They have a full time executive and an assistant plus eight to ten secretaries and dues are \$85 active and \$35 associate. They also engage a lobbyist and a lawyer. Special meetings are held with the Bar Association and the Public Health officials each month. A four page newsletter is printed each month which includes a synopsis of grievance cases and how they could have been avoided. The Society produces its own TV programs each week and has an annual dinner with members of the



press. Funds are available to widows and children of physicians and to rehabilitate physicians who have an alcohol or drug problem.

Philadelphia has an active membership of 4,500 physicians paying annual dues of \$100. The staff includes an executive director, public relations officer and 25 secretaries. They have 120 standing and active committees and two or three indoctrination sessions for new members. There are five dinner meetings each year at which they have awards and name lectureships. Approximately 220 members attend each meeting which must be limited to that number because of space, and about 500 people attend installation ceremonies. The Executive Committee meetings are held monthly as are Board of Directors meetings. The Society operates an answering service and its own press which do not make money. They have very large foundations which support many worthwhile projects such as scholarships and student loans. The Society sponsors a health institute for two days each year as an educational program and a self-evaluation program. Residents, interns, and medical students are members of the Society and participate in committee meetings.

York has 200 members whose dues are \$50 and has no paid staff except a part-time secretary. Harrisburg has 400 members paying \$50 per year. Both groups have a Med-Dental organization that

is separate from the societies which operates an answering service, collection agency, insurance, printing, etc.

The conclusions reached from the meeting were: (1) The local medical organization is the important one; (2) Society dues should be raised to support increased activity; (3) Bylaws should be altered to allow the medical students and house staff to become actively involved in the medical society; (4) Membership should be urged to assist in establishing a foundation that would be directed along humanitarian lines; (5) Liaison with Bar Association should be established to see what can be done to reduce growing number of lawsuits; (6) An educational program in the schools should be established on how health facilities which are now available can be fully utilized.

The suggestion was made that these recommendations and the report be referred to the Policy and Planning Committee for further consideration. A motion was then made, seconded, and unanimously approved that the President be commended for his efforts in arranging this meeting and providing the Board with the report.

There being no further business, the meeting was adjourned at 6 PM.

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# Letter to the Editor

Editor:

Peer review, as outlined in the April 1971 issue of the *Journal*, is an area of professional and self-evaluation which, if properly carried out, will benefit all concerned. Rendering the best patient care possible should be the first and foremost goal of every physician, and judicious selection of diagnostic tests is an important facet of such care.

Since a substantial part of my practice is in the domain of consultation, I have reviewed many, many patients' charts. Often I have been appalled at the volume of examinations which have yielded little or no useful information. While a careful selection of appropriate tests and mechanical procedures is worthwhile, the irrational, wholesale ordering of tests in a hit-and-miss manner represents a poor, disorganized, and almost frantic effort to solve the diagnostic problem without taxing one's own mental resources. There are times, in fact, when a positive test result may have no bearing on the patient's particular problem; yet it may draw the doctor's attention away from his better clinical judgment.

As the Peer Review Committee has been charged with analyzing the "quality, need for services rendered, and applicability of the medical care provided to a patient" and to assure that such services "are provided only when necessary," I solicit the committee's attention to a matter of particular concern to me: the overuse of the gastroscope. Not too long ago I was on a committee appointed by the chief of medical service at one of our hospitals to investigate the sudden dramatic and unexplainable increase in the number of gastroscopies being done at that hospital. After reviewing a large number of gastroscopies, the committee concluded that even under the most lenient circumstances, at least half of them were performed unnecessarily. In some cases, the information obtained was actually misleading. We noted, too, that in conjunction with the gastroscopies, a large number of routine biopsies were performed. Although the word "biopsy" carries the connotation of a definitive diagnosis, if it is not taken from the right site, or if it proves to be negative when the accumulated clinical evidence indicates otherwise, a disservice has been done. A case can be made for the opposite situation, that is, positive information especially of a visual sort, where nothing of real significance is actually present.

As a gastroenterologist thoroughly familiar with gastroscopy (I was the first to perform the procedure in several of our hospitals), I would consider it a real accomplishment of the Peer Review Committee to determine how many gastroscopies performed in this state are unnecessary, either because the diagnosis is already apparent or because

there is no real likelihood that it will contribute enough information to warrant the time and expense involved (or always possible, although unlikely, the added risk to the patient).

If we are to foster good medical practice, we must put the brain back to work and get the doctor back to the patient. I am reminded of a cartoon depicting two men dressed in white in a room with a large examining table covered with a variety of test tubes and instruments. The setting implied that every test possible had been done on the patient (or the victim). Said one doctor to the other, "I guess we will have to see the patient after all."

In closing, I would like to quote from the article ("Peer Review in the State of Maryland") in the April 1971 issue of the *Maryland State Medical Journal*: "Individually, we have wrung our hands and berated rising hospital costs, unnecessary admissions, and prescribing or 'shooting the works' in ordering x-rays or laboratory services". (Emphasis mine.) It is always the other guy, never ourselves, who is guilty of such practices. We have overlooked the fact that it is the individual physician who admits and discharges the patient, and who orders the services the patient receives. *The services we order and the competitive gadgetry we demand at our hospitals are major factors in cost escalation.*" (Emphasis mine.)

Later in the article, it is stated that the attention of professional or peer review groups will be directed, among other objectives, toward "determining whether the services are necessary to proper health care" and also toward "providing care in the most economical fashion consistent with recognized standards of care".

I would conclude that if ever a peer review committee could do good, it would be in controlling this overusage of tests and procedures in an effort to get back to a well-planned systematic approach to diagnosis and, consequently, treatment.

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**Caution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

**Supplied:** Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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## POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



**functional  
bowel distress  
spastic and  
irritable  
colon**



Lido



# move up to "the Robinul response"

when lower  
G-I symptoms  
demand  
a potent  
synthetic  
antispasmodic

In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital—warning: may be habit forming).

## Robinul® 2mg. Forte (glycopyrrolate)

■ **INDICATIONS** Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va.

A-H-ROBINS







# The all-day, all-night summer cold and allergy pill.

Novahistine LP can give your patients the convenience of twice-a-day dosage—morning and bedtime—along with prompt relief from the symptoms of allergic rhinitis, hay fever or summer colds. These continuous-release tablets contain a vasoconstrictor-antihistamine formulation that goes to work rapidly and lasts for hours. Even when nasal congestion is the result of repeated allergic episodes, patients can usually enjoy around-the-clock relief. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.



THE DOW CHEMICAL COMPANY, Rx Pharmaceuticals, Indianapolis

**Novahistine<sup>®</sup>**  
**LP** decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)



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**CARLA C**

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# **SEMIANNUAL MEETING**

**September 15-19, 1971**

**Medical and Chirurgical Faculty of Maryland**

**at the**

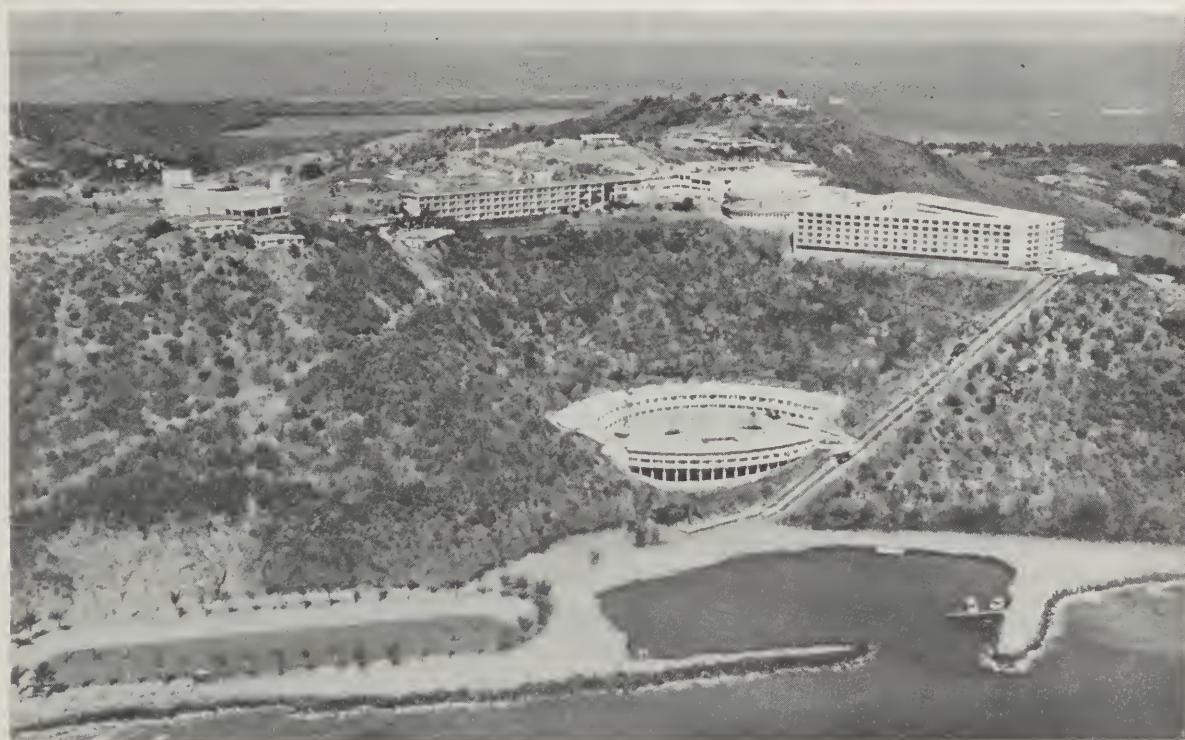
**El Conquistador Hotel and Club**

**Las Croabas, Puerto Rico**

**Daily Scientific Sessions**

**and**

**Woman's Auxiliary Meetings**



**THE EXTRAORDINARY SETTING FOR  
MED-CHI'S 1971 SEMIANNUAL MEETING**



MEDICAL AND CHIRURGICAL FACULTY OF

THE STATE OF MARYLAND

1971 SEMIANNUAL MEETING

SEPTEMBER 15 TO 19, 1971

EL CONQUISTADOR HOTEL AND CLUB

LAS CROABAS, PUERTO RICO

SEPTEMBER 15

Depart in the morning from Friendship Airport in Baltimore via EASTERN AIRLINES 747 JUMBO JET . . . the world's newest, largest, fastest, smoothest, most comfortable jetliner. Enjoy a leisurely breakfast high in the clouds and, flying swiftly, you will be in the "swingingest" island of them all in a few fleeting hours.

Upon arrival at the airport, you will be met and whisked through the countryside to the EL CONQUISTADOR HOTEL AND CLUB, a 380-acre paradise on the east coast of Puerto Rico, surrounded by sun, sea and a dazzling view of the Virgin Islands, the Caribbean Sea and the Atlantic Ocean . . . the extraordinary setting for the MED-CHI's 1971 SEMIANNUAL MEETING.

Here Med-Chi members will spend an unforgettable succession of five sun-splashed days and four balmy nights of sheer pleasure in ultraluxurious accommodations, each with its own private balcony and a breathtaking view of the sea. Baggage will be brought to the hotel and placed directly in each tour member's room.

After the **DAILY SCIENTIFIC SESSIONS**, every luxury and resort activity one could possibly desire is available to make the meeting in this enchanting island where old Spain meets the new world a wonderfully relaxing experience.

There are two fresh water Olympic-size pools and an ocean pool surrounded by a palm-fringed beach. Unique aerial tramways and funiculars glide from level to level.

There's an 18-hole championship golf course, tennis courts, horseback riding and a health spa replete with every kind of bath, massage rooms and rooftop solarium.

Sailing, deep-sea fishing and all water sports are available from the hotel's own 75-boat marina. And for the fabulous free port shopping, St. Thomas in the Virgin Islands is nearby.

The cocktail lounges swing and "Anything Goes at Sugar's" is a madcap night club and discotheque.

Just let your mood set the pace from "dawn to yawn" for an unforgettable convention at this posh planet of pleasure where even seeing isn't believing.



## SEPTEMBER 15-19

**During the Semiannual Meeting, included are:**

- Full multicourse breakfast each morning.
- DAILY SCIENTIFIC SESSIONS—10 AM to 12 noon and 2:00 PM to 4:30 PM.
- MEETINGS OF THE WOMAN'S AUXILIARY.
- Dinner each evening in the opulent setting of the Sovereign's Court.
- Welcome Rum Swizzle Party . . . a delightful tropical treat and specialty of this heavenly paradise.
- Gala Farewell Party . . . cocktails, banquet and dancing in the magnificent Casals Hall . . . a grand finale to THE 1971 MED-CHI SEMIANNUAL MEETING.

## SEPTEMBER 19

Passengers and baggage will be transferred from the hotel to the airport for the return flight via nonstop 747 Jumbo Jet, the biggest bird in the sky. Enjoy a delightful dinner and the continuous complimentary bar while soaring over the ocean at nearly the speed of sound.

Alight from the plane at Friendship Airport in Baltimore relaxed and refreshed after five wonderful days in the sun enjoying the best that Puerto Rico has to offer. You will feel as if you have been on more than just a convention . . . you have also been on a vacation!

\* \* \* \*

All-inclusive cost—\$239 a person

First Class Supplement—\$25 a person

Supplemental cost for single room—\$48

Tax and service—\$19.50 (including baggage handling, gratuities to porters, waiters, beach boys, doormen, and chambermaids, departure tax and hotel tax.)

\* \* \* \*

Reservations for the Semiannual Meeting can only be confirmed upon receipt of a deposit in the amount of \$50 a person. All deposits and monies paid are refundable in full until August 1, 1971. After this date, refunds are subject to resale of the reservation(s)

**ALL DEPOSITS ARE TO BE MADE PAYABLE TO TRAVEL GUIDE AGENCY, LTD. AND MAILED TO COMMITTEE ON PROGRAM AND ARRANGEMENTS, MEDICAL AND CHIRURGICAL FACULTY, 1211 CATHEDRAL STREET, BALTIMORE, MARYLAND 21201.**

For further information, contact the FACULTY OFFICE, (301) 539-0872 OR Mrs. Beverly Wolins at (301) 727-0680.

See Reservation Form on Page 41

## BUSINESS MEETINGS

SEPTEMBER 11, 1971

FACULTY BUILDING, 1211 CATHEDRAL STREET, BALTIMORE

John F. Schaefer, MD, *President*  
John B. De Hoff, MD, *Chairman*  
Committee on Program and Arrangements



# she has a plan that works





She has a plan that works.  
She has one plan for the  
class. And they really respond.

She has another plan just  
for herself. A medication plan  
for her hypertension. And she's  
also responding beautifully.

More than just another  
antihypertensive, Ser-Ap-Es  
can be a whole medication plan  
for living with hypertension.

Does it get good marks for  
comfort?

Excellent. Because  
Ser-Ap-Es controls blood pressure  
effectively, dosage of each  
component is lower than if prescribed  
alone, usually minimizing  
side effects. However, side  
effects may occur (see prescribing  
information).

Designed with the kidney  
in mind?

Hydralazine maintains  
or increases renal blood flow.

And the brain too?

Hydralazine also relaxes  
cerebral vascular tone. And  
reserpine has beneficial calming  
action.

Is strict dietary discipline  
necessary?

Hydrochlorothiazide  
eliminates excess salt and  
water. So dietary salt restrictions  
can be relaxed a bit.

Practical on a teacher's  
salary?

Ser-Ap-Es means single-  
prescription economy.

Will she do her  
"homework"?

More than likely.  
Ser-Ap-Es offers all the anti-  
hypertensive medication  
many patients need in a single  
tablet. It's easier. Encourages  
cooperation.

Ser-Ap-Es supplies many  
kinds of benefits...

Only Ser-Ap-Es adds  
Apresoline® (hydralazine) to  
rauwolfia-thiazide.

Please turn page for brief  
prescribing information.

C I B A

# Ser-Ap-Es®

reserpine 0.1 mg  
hydralazine hydrochloride 25 mg  
hydrochlorothiazide 15 mg

## a plan for living with hypertension



# Ser-Ap-Es®

reserpine  
hydralazine hydrochloride  
hydrochlorothiazide

0.1 mg  
25 mg  
15 mg

**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

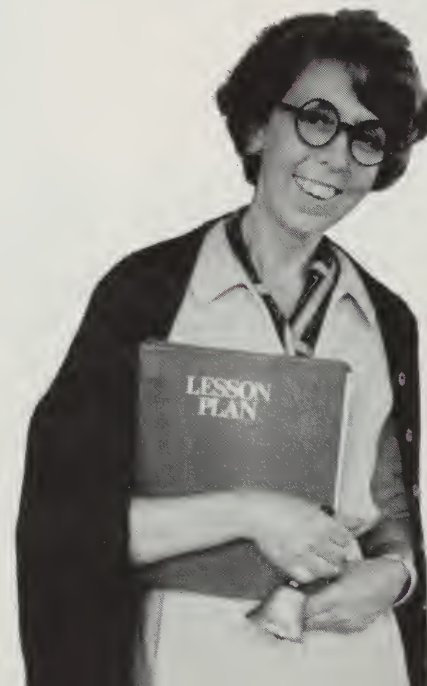
**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

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Summit, New Jersey

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she has a plan  
that works  
for living with  
hypertension

# Ser-Ap-Es®

reserpine 0.1 mg  
hydralazine hydrochloride 25 mg  
hydrochlorothiazide 15 mg

# C I B A



The **Aero Club of Baltimore** is sponsoring a nonprofit community project devoted to overcoming the fear of flying among individuals who are interested in aviation travel but are handicapped by pathological aversion to flying. Many wish to fly but cannot bring themselves to take the first step.

The program is under the supervision of a qualified psychiatrist and consists of 15 sessions of group therapy, including visits to the airport. An excursion flight is planned at the end of the course.

A nominal charge of \$10 per session, payable in advance to the Aero Club, is necessary to meet expenses. For information regarding the course, write: Fearless Flying Program, Aero Club of Baltimore, 22 Light Street, Baltimore, Maryland 21202.

\* \* \*

**A. McGhee Harvey, MD**, professor and director of the Department of Medicine at The Johns Hopkins University, was elected a Master of the American College of Physicians at its recent meeting. Master is the highest membership category in the 17,000-member international medical society.

\* \* \*

**John C. Norton, Jr., MD**, was installed as a Fellow of the American College of Obstetrics and Gynecologists at its annual meeting in San Francisco. The announcement was made by Alvin Powers, director of Bon Secours Hospital.

Dr. Norton has been a member of the staff at Bon Secours since 1946 and served as president of the staff during 1968 and 1969.

\* \* \*

The **American Medical Association Council on Environmental and Public Health** reports that gonorrhea ranks first and syphilis third among the reported communicable diseases in the

## MEDICAL NEWS

United States. For the year ending June 30, 1970, infectious syphilis rates were 8% higher nationally than a year earlier, with annual increases spread over 33 states. There was also an estimated incidence between 70,000 to 80,000 reported cases of all forms of syphilis estimated to be diagnosed and treated each year. At the same time, gonorrhea morbidity exceeded 573,000 reported cases. Gonorrhea is pandemic in the United States, with an estimated two million cases. The Council urges medical societies to acquaint their membership with the growing and alarming dimensions of the VD problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

\* \* \*

The cooperation of physicians is requested in the referral of children with **Hand-Schuller-Christian disease** for a study being conducted by the **National Institute of Child Health and Human Development's Reproduction Research Branch**, at the **Clinical Center, National Institutes of Health in Bethesda**.

Of particular interest for this therapeutically oriented study are children with manifestations of diabetes insipidus or growth retardation of Hand-Schuller-Christian disease. Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings. Physicians interested in having their patients considered for admission to these studies may write or telephone: **Peter O. Kohler, MD**, or **Griff T. Ross, MD**, **Clinical Center, Room 10-B-09, National Institutes of Health, Be-**

**thesda, Maryland 20014, Telephone: (301) 496-4686.**

\* \* \*

**James D. Shepperd, Jr., MD**, has been named medical director of the East Baltimore Medical Plan and assistant professor of medicine at The Johns Hopkins University School of Medicine. As medical director for the new prepaid, comprehensive health-care plan, Dr. Shepperd will be responsible for the administration and delivery of the plan's medical and health services.



**Dr. Shepperd**

\* \* \*

**Franklin R. Stuart, MD**, resident in orthopedic surgery at the University of Maryland School of Medicine, has won for his research project, **Heterotrophic Ossification in the Paraplegic and Quadriplegic Patient**, a Research Project Fund grant from the Southern Medical Association.

\* \* \*

**Robert W. Gibson, MD**, Medical Director at the Sheppard and Enoch Pratt Hospital, has been named President-elect of the Central Neuro-Psychiatric Hos-



pital Association. The election took place at the association's annual meeting on March 11, 1971.

\* \* \*

**Kent E. Robinson, MD**, Director of Sheppard and Enoch Pratt Outpatient Services, moderated a panel on "The Life Styles of Non-Patient Homosexuals" at the 124th annual meeting of the American Psychiatric Association in Washington, D.C. on May 6, 1971. Dr. Robinson also presented a paper on "Violence and the Cowboy Legend" at the same meeting.

\* \* \*

**The Maryland State Department of Education** has granted approval for the Sheppard-Pratt Mount Airy High School to offer nonpublic secondary school program for emotionally disturbed children. As a result of this recent accreditation, the Mount Airy School can now issue high

school diplomas both as a regular and as a special school.

\* \* \*

Maryland now has a new program to attract returning armed forces medical personnel into civilian health careers in the state.

Initiated by the Maryland Comprehensive Health Planning Agency (MCHPA), in conjunction with a similar nationwide effort, the project is known as **MEDIHC (Military Experience Directed Into Health Careers)**.

"These returning servicemen represent a tremendous untapped resource of medically trained manpower," according to Dr. Eugene H. Guthrie, Executive Director of MCHPA. "Studies show that more than 30,000 servicemen who have received 20 or more weeks of paramedical training followed by one to two years of experience are released from the armed forces each

year, and these skills are badly needed in our health care institutions."

The program will be administered under contract with the State Department of Health and Mental Hygiene by Maryland Hospital Education and Research Foundation, Inc., a private nonprofit foundation working with the problems of health manpower in the state.

\* \* \*

**Georgeanna Seegar Jones, MD**, President of the Fertility Society and Associate Professor of Gynecology and Obstetrics at The Johns Hopkins, chaired a symposium on population dynamics sponsored by Ortho Pharmaceutical Corporation at the Society's annual meeting in New Orleans. The symposium compared mankind's multiplication with that of yeast cells, which grow in numbers until they poison their own environment and inadvertently commit suicide.

**Georgeanna Seegar Jones, MD**, President of the Fertility Society and Associate Professor of Gynecology and Obstetrics at The Johns Hopkins, speaks on population dynamics at the society's annual meeting in New Orleans.



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The actions of the official  
Tincture and Extract of  
Belladonna result chiefly from  
their Atropine content . . .  
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS  
3rd Edition, page 522



# ANTROCOL<sup>®</sup>

*Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.*



Each tablet or capsule contains:  
Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

#### SUPPLIED

Tablet in bottles of  
100, 500 and 5000  
Capsule in bottles  
of 100, 500 and 1000

Caution: Federal law prohibits  
dispensing without prescription.

#### PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

**DOSAGE:** One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

*Clinical supply available to physicians.*

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# Clinical Extension of a pure Smooth Muscle Relaxant

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Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

*DIARRHEA (functional) . . . the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

*DIVERTICULITIS—MUCOUS COLITIS . . . the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

*BLADDER SPASM . . . relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

*SPASTIC URETER . . . the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

### PRESCRIBING INFORMATION

**WARNING:** Do not give in advanced kidney or liver disease.

**PRECAUTIONS:** Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. **DOSAGE:** 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

**NOTE:** The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.

WILLIAM P. POYTHRESS & CO., INC.  
RICHMOND, VIRGINIA 23217

*Manufacturers of Ethical Pharmaceuticals*





# MINUTES

First Meeting, 173rd Annual Session, House of Delegates

(271st Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Wednesday, May 12, 1971

Baltimore Civic Center, Baltimore, Maryland

The 271st meeting, first of the 173rd Annual Session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:35 AM, Wednesday, May 12, 1971, at the Baltimore Civic Center, Baltimore, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors: Manning W. Alden, Council; A. Maynard Bacon, Jr., Washington County; Charles Bagley, III, Wicomico County; Timothy D. Baker, Baltimore City; John G. Ball, Council; James W. Banks, Washington County; Robert A. Barnett, Montgomery County; Richard D. Bauer, Past President; Emidio A. Bianco, Baltimore City; Norman K. Bohrer, Prince George's County; Francis J. Borges, Baltimore City; Samuel Borssuck, Anne Arundel County; M. McKendree Boyer, Council; \*Herman Brecher, Baltimore City; Henry A. Briele, Council; Robert vL. Campbell, Council; D. Delmas Caples, Baltimore County; John T. Chissell, Council; \*Thomas Cimonetti, Howard County; Archie Robert Cohen, Washington County; Edward F. Cotter, Baltimore City; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Richard Y. Dalrymple, Council; Worth B. Daniels, Jr., Baltimore City; H. Vincent Davis, Cecil County; Melvin B. Davis, Baltimore County; Matthew Debuskey, Baltimore City; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; John M. Dennis, Council; \*Marshall A. Diamond, Montgomery County; \*Michael Dobridge, Montgomery County; Robert W. Farr, Kent County; George G. Finney, Jr., Baltimore City; Vincent J. Fiocco, Jr., Carroll County; \*Ronald H. Fishbein, Baltimore City; Elliott R. Fishel, Baltimore City; Russell S. Fisher, Council; \*William E. Gilmore, Baltimore City; Sylvan D. Goldberg, Baltimore City; Robert B. Goldstein, Council; E. Gordon Grau, Baltimore County; George H. Greenstein, Baltimore City; Wilson Grubb, Baltimore City; \*J. Roy Guyther, St. Mary's County; William B. Hagan, Council; Louis E. Harmon, Baltimore City; Thurston Harrison, Talbot County; John Collins Harvey, Council; Thomas Franklyn Herbert, Howard County; C. Earl Hill, Anne Arundel County; John Hyle, Baltimore County; J. Parran Jarboe, Council; D. Frank Kaltreider, Council; William H. Kammer, Jr., Baltimore City; Arthur T. Keefe, Jr.,

Council; Bender B. Kneisley, Past President; Louis J. Kolodner, Council; Edward L. J. Krieg, Baltimore County; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Charles H. Ligon, Council; J. Richard Lilly, Prince George's County; Elmer G. Linhardt, Board of Medical Examiners; Francis C. Mayle, Jr., Montgomery County; Karl F. Mech, Council; \*Joseph T. Michels, Baltimore City; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore City; Marvin I. Mones, Montgomery County; \*Arturo M. Monteiro, Charles County; \*Paul A. Mullan, Baltimore City; \*Charles F. O'Donnell, Council; Joseph Allan Offen, Montgomery County; Stephen K. Padussis, Baltimore City; William A. Pillsbury, Council; Thaddeus E. Prout, Baltimore City; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; William F. Renner, Baltimore City; Philip L. Repetto, Jr., Prince George's County; \*William Roemmich, Baltimore County; \*Norman E. Sartorius, Jr., Worcester County; John F. Schaefer, Council; Richard Michael Schisgall, Montgomery County; Margaret Lee Sherrard, Baltimore County; George Simons, Allegany County; Arthur G. Siwinski, Council; R. Kennedy Skipton, Prince George's County; Gordon M. Smith, Montgomery County; Roland T. Smoot, Baltimore City; \*J. Walter Smyth, Baltimore City; Aaron C. Sollod, Baltimore City; William G. Speed, III, Council; George R. Spence, Montgomery County; \*Stanley R. Steinbach, Baltimore City; \*William N. Thomas, Jr., Anne Arundel County; Chris P. Tountas, Baltimore City; Francis J. Townsend, Jr., Worcester County; \*Richard F. Tyson, Baltimore City; John B. Umhau, Montgomery County; Thomas E. Van Metre, Jr., Baltimore City; Sidney J. Venable, Baltimore County; Hugh W. Ward, Calvert County; Daniel I. Welliver, Council; William C. Weintraub, Prince George's County; Lawrence R. Wharton, Jr., Baltimore City; Charles E. Wright, Frederick County; N. Louise Young, Baltimore City; Raymond M. Yow, Council.



Present also were staff personnel.

Martin L. Singewald, MD, Chairman of the Faculty's Committee on Medicine and Religion, delivered the invocation. **INVOCATION**

The President made several announcements regarding the manner of conducting the business at the session. **ANNOUNCEMENTS**

The minutes of the House of Delegates, Semiannual Session, Hershey, Pa., on September 11, 1970, having been distributed to members and having been approved by the Executive Committee, were presented to the House for information. **MINUTES**

Rhoslyn J. Bishoff, MD, President, Medical Society of Delaware; and Emanuel M. Satulsky, MD, President, Medical Society of New Jersey, were introduced to the House and spoke briefly. **INTRODUCTION OF GUESTS**

After the Secretary read the following names of deceased members, the members of the House of Delegates rose in observance of a moment's silence in respect for their deceased colleagues: **NECROLOGY**

#### Allegany County

Davis, John B.	October 11, 1970
Rees, David T.	April 8, 1970
Strong, A. Paige	September 20, 1970

#### Baltimore City

Buchness, John A.	November 18, 1970
Buxton, Robert W.	August 14, 1970
Carozza, Frank A., Jr.	October 13, 1970
Clough, Paul W.	May 11, 1970
Crocker, Melvin H.	December 27, 1970
Cumin, Milton H.	June 14, 1970
Douglas, Carleton C.	July 2, 1970
Govatos, George	August 2, 1970
Hinno, Juri	July 16, 1970
Jacobs, Morris A.	September 19, 1970
Johnson, William R.	April 26, 1970
Levy, Charles S.	February 24, 1970
Miller, Joseph G.	October 31, 1970
Reckling, Ralph W.	March 28, 1971
Reifschneider, Herbert E.	November 28, 1970
Richardson, Edward H.	January 15, 1971
Rosenthal, Gilbert W.	December 10, 1970
Saar, Arthur	March 23, 1971
Saunders, Leroy W.	March 9, 1971
Sheppard, Henry	May 25, 1970
Skloven, Joseph	April 9, 1971
Smith, Howard Chandler	August 15, 1970
Stewart, C. Wilbur	October 16, 1970
Walker, W. Wallace	December 4, 1970

#### Baltimore County

Edwards, William H.	April 27, 1970
Kieffer, George S. M.	July 9, 1970
Morrison, W. Herbert	February 13, 1971

#### Caroline County

George, D. O.	December 21, 1970
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#### Carroll County

Bush, Joseph E.	October 25, 1970
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#### Cecil County

Benson, Clarence I.	September 1, 1970
Richards, G. Hampton	March 7, 1971

#### Frederick County

Smith, J. G. F.	March 13, 1970
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#### Harford County

Finney, James McC.	August 28, 1970
Palmer, Gerald C.	March 8, 1970

#### Howard County

Shipley, Frank E.	April 2, 1971
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#### Montgomery County

Starr, Paul V.	April 8, 1970
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#### Prince George's County

Burns, Cornelius J.	April 1, 1971
Schwartzbach, Saul	November 1, 1970

#### Somerset County

Lewis, Archie C.	May 17, 1970
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#### Talbot County

Reeser, Guy M., Jr.	October 1, 1970
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#### Washington County

Mowrer, C. L.	October 7, 1970
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#### Affiliate

Chase, James W., Jr., Dover, Delaware

The President awarded 50-Year pins to the following members who were present for the meeting: **PRESENTATION OF 50-YEAR PINS**

E. W. Ditto, Jr., MD, Washington County  
Bender B. Kneisley, MD, Washington County

On motion of the Council Chairman, Dr. Alden, the following members who had received the recommendation of their respective societies and the Council, were elected to Emeritus Membership in the Faculty: **EMERITUS MEMBERSHIP**

Baltimore City: Louis C. Dobihal, MD, Baltimore  
R. Walter Graham, MD, Baltimore  
Sigmund R. Nowak, MD, Baltimore  
Alexander A. Weinstock, MD, Baltimore

Carroll County: Ilse Kamm, MD, Sykesville

Executive Committee: Caroline A. Chandler, MD, Glen Arm

Karl F. Mech, MD, Treasurer, presented the 1971 budget for information of the House, this having been adopted by the Council. The Treasurer advised that the Faculty's books had been audited and that the printed audit would be available at the Semiannual Session. The report of the auditors that the books and records had been **TREASURER'S REPORT AND 1971 BUDGET**



examined and found correct was approved by general consent.

Charles F. O'Donnell, MD,  
Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than the required two-thirds vote:

- (a) Amend Article II, Section 4, after the words, "greatly limited" and before the words, "they shall" by inserting:

"The Council, of its own motion and without the request of a component society, may recommend to the House of Delegates for Emeritus Membership any Affiliate member under the provisions of Article II, Section 3(2), provided they meet all of the requirements of this section."

- (b) Amend Article XI, Section 19 by striking the entire section and substituting the following new sections (the remaining sections being automatically renumbered):

Section 19. A COMMITTEE ON CONTINUING MEDICAL EDUCATION of at least eight members shall consider and advise upon postgraduate educational programs, all phases of medical education, including hospital educational programs, such as residency training programs. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. Its chairman shall be appointed by the President; with the members of the committee appointed by the chairman, with the approval of the President.

Section 20. A COMMITTEE ON PREVENTIVE MEDICINE AND PUBLIC HEALTH of at least five members shall consider and advise upon all aspects of health maintenance, preventive medicine and public health. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. Its chairman shall be appointed by the President; with the members of the committee appointed by the chairman, with the approval of the President.

- (c) Amend Article III, Section 1 (a) by substituting for it the following:

"(a) *For Active Members:* \$45.00 for the first year in private practice; \$55.00 for the second year in private practice; \$95.00 annually thereafter."

This amendment will take effect in the 1972 dues year and thereafter.

The Secretary, on behalf of the House of Delegates, and in conformity with action taken at the Semiannual session, moved adoption of the following resolution which, after debate, was adopted by more than a two thirds vote as follows:

Resolved, That an assessment be imposed on all Active members in the amount of \$5 for an indefinite period, to be paid at the same time and in the same

manner as dues by all Active members for the purpose of continuing medical education.

John F. Schaefer, MD,  
President-elect, offered the following resolution in memory of a distinguished member who had died during the previous year, which was adopted unanimously:

### **SPECIAL RECOGNITION OF DECEASED MEMBER**

*GUY M. REESER, MD*  
St. Michaels, Maryland 1923-1970

Whereas, Guy M. Reeser, MD, of St. Michaels, Maryland, served as an outstanding example of a Family Physician; and

Whereas, During his lifetime he served in many illustrious posts, such as: President of the Maryland Academy of General Practice; President of the Talbot County Medical Society; President of the Rotary Club in Talbot County; Town Commissioner and Mayor of St. Michaels; and

Whereas, This type of activity indicated his abiding interest and concern for his fellow citizen; and

Whereas, The profession of medicine, while producing leaders in all walks of life, owes much to individuals such as Dr. Reeser; therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland honor one of its leading members who died in a freak accident on October 1, 1970 while pursuing one of his avocations; and

Resolved, That this House of Delegates observe a moment's silence to honor his memory; and

Resolved, That a copy of this resolution be spread upon the minute books of this House of Delegates session and that a copy be sent to his family.

Dr. Mech commented on two other distinguished members who had died during the previous year and asked for recognition of their contributions to the profession. They were:

Robert W. Buxton, MD, Baltimore

Frank E. Shipley, MD, Savage

The House unanimously took such action.

Russell S. Fisher, MD, Nominating Committee Chairman, presented the following slate:

### **NOMINATING COMMITTEE REPORT**

President-elect

DeWitt E. DeLawter, MD, Bethesda—(President-elect 1971-72, President 1972-73)

First Vice President

Edwin R. Ruzicka, MD, Easton (1973)

Second Vice President

Katherine H. Borkovich, MD, Baltimore (1973)

Third Vice President

Manning W. Alden, MD, Annapolis (1973)

Secretary

William A. Pillsbury, MD, Timonium (1973)

### **MEDICAL EDUCATIONAL ASSESSMENT**



**Treasurer**

Karl F. Mech, MD, Baltimore (1973)

**Councilors**

**Central District**

Louis J. Kolodner, MD, Baltimore (1975)

Louis J. Kolodner, MD, Baltimore (1971-72)

(to fill unexpired term of Robert C. Kimberly, MD, resigned)

**South Central District**

Frederick E. Musser, MD, College Park (1975)

**Southern District**

Elmer G. Linhardt, MD, Annapolis (1975)

**Western District**

Richard Y. Dalrymple, MD, Westminster (1975)

Robert J. Thomas, MD, Frederick (1975)

**Delegate to the American Medical Association**

Robert vL. Campbell, MD, Hagerstown

(Jan. 1, 1972—Dec. 31, 1974)

**Alternate Delegate to the American Medical Association**

William Carl Ebeling, MD, Towson

(Jan. 1, 1972—Dec. 31, 1974)

**Committee on Program and Arrangements**

Edwin H. Stewart, MD, Baltimore (1972-76)

**Library and History Committee**

Katharine A. Chapman, MD, Kensington (1972-77)

**Finney Fund Committee**

D. C. W. Finney, MD, Baltimore (1977)

**Board of Medical Examiners**

J. Roy Guyther, MD, Mechanicsville (June, 1971-June, 1975)

Gerald A. Galvin, MD, Baltimore (June, 1971-June, 1975)

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent, the election to be held at the second meeting of the session, Friday, May 14, 1971, at the Faculty building. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, 12 Noon, May 13, 1971, at the Baltimore Civic Center.

Certain other announcements were made and there being no

**ANNOUNCEMENTS**

further business the President, by unanimous consent, declared the House adjourned at 10:50 AM until 2 PM, Friday, May 14, 1971, at the Faculty building.

WILLIAM A. PILLSBURY, MD, *Secretary*

**Second Meeting, 173rd Annual Session, House of Delegates**

**(272nd meeting)**

**Medical and Chirurgical Faculty of the State of Maryland**

**Friday, May 14, 1971**

**Faculty Building**

The 272nd meeting, second of the 173rd Annual Session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 2:05 PM, Friday, May 14, 1971, at the Faculty Building, 1211 Cathedral St., Baltimore, Maryland, the President and Acting Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors: Manning W. Alden, Council; Charles Bagley, III, Wicomico County; Timothy D. Baker, Baltimore City; John G. Ball, Council; Emidio A. Bianco, Baltimore City; Francis J. Borges, Baltimore City; M. McKendree Boyer, Council; \*Herman Brecher, Baltimore City; Henry A. Briele, Council; Robert vL. Campbell, Council; John T. Chissell, Council; \*Thomas Cimonetti, Howard County; Archie Robert Cohen, Washington County; Edward F. Cotter, Baltimore City; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; \*Raymond M. Cunningham, Baltimore City; Worth B. Daniels, Jr., Baltimore City; Melvin B. Davis, Baltimore County; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; \*John F. Eyring, Baltimore City; George G. Finney, Jr., Baltimore City; Vincent J. Fiocco, Jr., Carroll County; Elliott R. Fishel, Baltimore

City; Russell S. Fisher, Council; Sylvan D. Goldberg, Baltimore City; Robert B. Goldstein, Council; George H. Greenstein, Baltimore City; Wilson Grubb, Baltimore City; \*J. Roy Guyther, St. Mary's County; William B. Hagan, Council; Thurston Harrison, Talbot County; C. Earl Hill, Anne Arundel County; Gunther D. Hirsch, Harford County; \*A. Clark Holmes, Prince George's County; \*Edward O. Hunter, Baltimore City; J. Parran Jarboe, Council; William H. Kammer, Jr., Baltimore City; Arthur T. Keefe, Jr., Council; Edward L. J. Krieg, Baltimore County; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Charles H. Ligon, Council; J. Richard Lilly, Prince George's County; Emory J. Linder, Harford County; Elmer G. Linhardt, Board of Medical Examiners; Francis C. Mayle, Jr., Montgomery County; Karl F. Mech, Council; \*Joseph J. Michels, Baltimore City; B. Martin



Middleton, Council; Donald W. Mintzer, Baltimore City; Joseph Allan Offen, Montgomery County; Hilary T. O'Herlihy, Anne Arundel County; Stephen K. Padusis, Baltimore City; Thaddeus E. Prout, Baltimore City; \*Talmadge Reeves, Wicomico County; Thomas R. Reid, Frederick County; William F. Renner, Baltimore City; Philip L. Repetto, Jr., Prince George's County; Antonio M. Rivera, Anne Arundel County; Edwin R. Ruzicka, Talbot County; John F. Schaefer, Council; \*Thomas Schnebly, Montgomery County; \*Henry Scruggs, Montgomery County; Margaret Lee Sherrard, Baltimore County; R. Kennedy Skipton, Prince George's County; Gordon M. Smith, Montgomery County; Roland T. Smoot, Baltimore City; Aaron C. Sollod, Baltimore City; William G. Speed, III, Council; George R. Spence, Montgomery County; \*Stanley R. Steinbach, Baltimore City; Francis J. Townsend, Jr., Worcester County; Thomas E. Van Metre, Jr., Baltimore City; Sidney J. Venable, Baltimore County; Hugh W. Ward, Calvert County; William C. Weintraub, Prince George's County; Charles E. Wright, Frederick County; Raymond M. Yow, Council.

Staff personnel were also present.

The President designated Robert B. Goldstein, MD, to serve as Secretary in the absence of the Secretary, there being no objection from the House.

#### DESIGNATION OF SECRETARY

The President then made certain announcements regarding attendance at the general sessions of the Faculty, as well as other matters of interest.

#### ANNOUNCEMENTS

The following guests were introduced to the members of the House and made brief remarks:

#### INTRODUCTION OF GUESTS

James E. Moss, MD, President of the Virginia Medical Society  
George Callander, MD, President of the West Virginia Medical Society

The President advised the House that members of the Board of Medical Examiners had been elected in a general session held on Thursday, May 13, 1971, at the Baltimore Civic Center, as follows:

#### BOARD OF MEDICAL EXAMINERS ELECTION

J. Roy Guyther, MD, Mechanicsville  
Gerald A. Galvin, MD, Baltimore

There being no candidates nominated from the floor and there being only one candidate for each of the positions to be filled, by unanimous consent, the ballot was dispensed with. The following were then elected by voice vote:

#### ELECTION OF OFFICERS

President-elect  
DeWitt E. DeLawter, MD, Bethesda (President-elect 1971-72, President 1972-73)

First Vice President

Edwin R. Ruzicka, MD, Easton (1973)

Second Vice President

Katherine H. Borkovich, MD, Baltimore (1973)

Third Vice President

Manning W. Alden, MD, Annapolis (1973)

Secretary

William A. Pillsbury, MD, Timonium (1973)

Treasurer

Karl F. Mech, MD, Baltimore (1973)

Councilors

Central District

Louis J. Kolodner, MD, Baltimore (1975)

Louis J. Kolodner, MD, Baltimore (1971-72)  
(to fill unexpired term of Robert C. Kimberly, MD, resigned)

South Central District

Frederick E. Musser, MD, College Park (1975)

Southern District

Elmer G. Linhardt, MD, Annapolis (1975)

Western District

Richard Y. Dalrymple, MD, Westminster (1975)

Robert J. Thomas, MD, Frederick (1975)

Delegate to the American Medical Association

Robert vL. Campbell, MD, Hagerstown  
(Jan. 1, 1972-Dec. 31, 1974)

Alternate Delegate to the American Medical Association

William Carl Ebeling, MD, Towson  
(Jan. 1, 1972-Dec. 31, 1974)

Committee on Program and Arrangements

Edwin H. Stewart, MD, Baltimore (1972-76)

Library and History Committee

Katharine A. Chapman, MD, Kensington (1972-77)

Finney Fund Committee

D. C. W. Finney, MD, Baltimore (1972-77)

By unanimous approval of the House, Mrs. Raymond M. Yow, President of the Woman's Auxiliary to the

#### WOMAN'S AUXILIARY REPORT

Medical and Chirurgical Faculty of the State of Maryland, was granted permission to address the House. Mrs. Yow then reported briefly on the activities of the Auxiliary during her term as President.

Herbert H. Leighton, MD, on behalf of the Reference Committee, recommended that Resolution 1A/71 be referred to the Policy and Planning Committee. The House referred Resolution 1A/71 to the Policy and Planning Committee, which reads as follows:

#### REFERENCE COMMITTEE REPORT

Whereas, In 1962, as a result of a Professional Management Study, the Faculty considered the question of hiring a Professional Negotiator; and

#### RESOLUTION 1A/71 REFERRED TO POLICY AND PLANNING COMMITTEE

Whereas, Many convincing arguments were presented



at that time for the Faculty to take such action, including:

- a) Negotiation is a highly skilled art requiring special knowledge and training.
- b) The Government and other parties are always represented by a Professional Negotiator.
- c) Medical and Chirurgical Faculty in the past, has been represented by committees of physicians who, by and large, are untrained in negotiating skills.
- d) The committees change from time to time preventing any real continuity on a year-to-year basis.
- e) It will provide a consensus for the profession, whereas decisions are sometimes not reached for the benefit of the majority.
- f) Such a negotiator would know the appropriate time to reach a compromise in the best interests of the public.
- g) Continued contact with persons "on the other side" would make negotiation easier and more constructive.

and

Whereas, These arguments are still valid and, perhaps more so, because of the increasing number of prepayment mechanisms that are coming into play; therefore, be it

Resolved, That the Council of the Medical and Chirurgical Faculty of the State of Maryland be directed to seek out and employ a qualified negotiator, in whose charge would be placed the responsibility for dealing with third payment mechanisms under the policy direction of an appropriate committee; and be it further

Resolved, That the duties and responsibilities of such an individual include other related socioeconomic matters deemed appropriate by the Council.

Dr. Leighton, on behalf of the Reference Committee, recommended adoption of Resolution 2A/71. The House adopted Resolution 2A/71, which read as follows:

#### **RESOLUTION 2A/71 ADOPTED**

Whereas, There is an increasingly well documented need for controlling medical care costs, conserving hospital and skilled nursing home resources and making optimum use of scarce, highly trained medical manpower; and

Whereas, Many patients now cared for in hospitals or skilled nursing homes could receive less expensive, more appropriate care in their own homes through a well planned, well administered home care service; and

Whereas, In Maryland there is inadequate private and governmental financing to encourage development of such comprehensive home care service; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urges the formation of home health care services programs for the residents of Maryland; and

Resolved, That since many Blue Cross plans throughout

the country now offer home care services coverage to their subscribers, the Medical and Chirurgical Faculty of the State of Maryland requests that Maryland Hospital Services, Inc., work with the medical and related professions to formulate plans for home care services for its subscribers; and

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland take any necessary action to find methods for initiating and financing such a program under Medicaid and Medicare.

Dr. Leighton, on behalf of the Reference Committee, recommended that Resolution 3A/71 be adopted.

#### **RESOLUTION 3A/71 ADOPTED AS AMENDED**

The House, after debate and amendment, adopted Resolution 3A/71, which read as follows:

Whereas, There remains a critical shortage of family physicians in the State of Maryland; and

Whereas, It was hoped to relieve this shortage, at least in part, by developing a training program in Family Practice at the University of Maryland School of Medicine; and

Whereas, This program which has now been functioning for four years has already made significant strides in its goals of interesting students in Family Practice and training interns and residents in Family Practice; and

Whereas, This program has been in danger of foundering due to inadequacy of support from the administration of the Medical School, particularly inadequate funding and inadequacy of space; therefore, be it

Resolved, That the House of Delegates communicate its immediate concern to the Dean of the University of Maryland School of Medicine for the failure of commitment to support the Family Practice Program; and

Resolved, That the House of Delegates prevail upon the University of Maryland and its School of Medicine and the Johns Hopkins University and its School of Medicine, to establish a separate department of Family Practice at these Schools of Medicine, on equal par with the other major departments, in place of the present Division of Family Medicine at the University of Maryland School of Medicine which is under the Department of Medicine; and as a new department at the Johns Hopkins University School of Medicine; and that these separate departments be funded in a realistic manner in relation to their needs.

The Chair then made certain announcements, following which the new President was introduced to the House, and spoke briefly.

#### **ANNOUNCEMENTS**

The President, by general consent, declared the House adjourned, **NEW PRESIDENT** sine die at 2:30 PM.

ROBERT B. GOLDSTEIN, MD, *Secretary pro tempore*



# MEDICAL AND CHIRURGICAL FACULTY

## SEMIANNUAL MEETING

### RESERVATION FORM

Send to:

COMMITTEE ON PROGRAM AND ARRANGEMENTS  
MEDICAL AND CHIRURGICAL FACULTY  
1211 CATHEDRAL STREET  
BALTIMORE, MARYLAND 21201

I would like to make a reservation for the MED-CHI SEMIANNUAL MEETING at the El Conquistador Hotel, September 15 to 19, 1971. Enclosed please find a deposit in the amount of \$----- (\$50 a person, made payable to TRAVEL GUIDE AGENCY LTD.) for ----- reservations. The balance will be payable no later than six weeks before departure. Deposits and monies paid are refundable in full until six weeks before departure, after which date refund is subject to resale of the reservation(s).

( ) First Class Supplement at \$25 a person

( ) Single room desired at supplemental rate of \$48

NAME			ADDRESS		
CITY	STATE	ZIP CODE	(home)	PHONE	(office)

Please list clearly the full names of all participants:

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# MEDICAL AND CHIRURGICAL FACULTY

OF THE STATE OF MARYLAND



## MED-CHI

*Members Retirement Plan*

**TRUSTEE AND ADMINISTRATOR**

**Mercantile-Safe Deposit and Trust Company**

**INVESTMENT ADVISOR**

**T. Rowe Price and Associates, Inc.**

**LIFE UNDERWRITER**

**Shenandoah Life Insurance Company**

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FOR MORE INFORMATION DETACH AND MAIL SLIP DIRECTLY TO:

Name .....	<b>MED-CHI MEMBERS RETIREMENT PLAN 1211 Cathedral Street Baltimore, Maryland 21201</b>		
Address .....			
City .....	State .....	Zip Code .....	
Telephone Number .....	Date of Birth .....		
	(month)	(day)	(year)



# The causes of vaginitis are multiple



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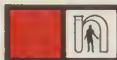
**Contraindications:** Known sensitivity to sulfanamides.

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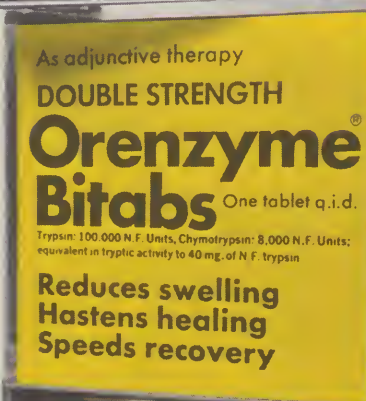
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MRS. WALLACE H. SADOWSKY, EDITOR

**woman's auxiliary**

## Introducing The Auxiliary's New President



**Mrs. Robert A. Reiter**

Mrs. Robert A. Reiter of Baltimore was installed as president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Mary-

land at the 22nd Annual Convention on May 13, 1971. Mrs. Reiter was a charter member of the Woman's Auxiliary to the Baltimore City Medical Society and has been active in medical auxiliary work since that time. On the board of the state medical auxiliary, she has held the offices of Historian, Legislation Chairman, Publicity Chairman and, most recently, Membership Chairman. She has held numerous positions on the Board of the Baltimore City Auxiliary and served as its president in 1969 and 1970.

Mrs. Reiter (Polly) earned her BS degree from the University of New Hampshire. She has always displayed leadership in community affairs: she served six years as a Girl Scout leader, and is a past-president of the P.T.A. She is also a past regent of the Maryland State Society Daughters of the Revolution and has served as editor of *The Patriot*, the publication of the National Society of Daughters of the Revolution. Both Polly and her husband are members of the Maryland Historical Society and have actively served on the committee to save the Carroll Mansion on Lombard and Front streets and the Flag House at Albemarle and Pratt streets, and the Constellation Committee.

Polly and Dr. Reiter, whose specialty is internal medicine, have two children, one daughter and one son. Their son, Robert Jr., is married, lives in Baltimore, and has three children. Their daughter, Ann Sargent Reiter, received her BS degree in nursing at the University of Maryland and is now working for the Veterans Administration Hospital in Boston.

The Reiters have traveled extensively throughout this country, the British Isles, Europe, and the Middle East. Polly's ties with medicine are evidenced



not only through her marriage and medical auxiliary work, but also through her hobby—studying the history of medicine. The Fall 1970 issue of *Hygeia Filiae* published an article written by Polly on the history of the name of our medical society, "Medical and Chirurgical Faculty".

The Auxiliary is fortunate to have Polly Reiter at its helm. Her knowledge of medical history can help improve the Auxiliary's future services to the medical profession. Following is a list of officers and committee chairmen who will be serving on the board with Polly:

President-elect	Mrs. Marvin L. Kolkin
First Vice-President	Mrs. Thaddeus H. Elder
Second Vice-President	Mrs. John N. Robinson
Third Vice-President	Mrs. Andre V. Fesus
Fourth Vice-President	Mrs. Leslie R. Miles
Recording Secretary	Mrs. Francis C. Mayle, Jr.
Treasurer	Mrs. S. G. Sullivan
Corresponding Secretary	Mrs. Robert W. Garis
Parliamentarian	Mrs. William S. Stone
AMA-ERF	Mrs. Elmer G. Linhardt
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Convention	Mrs. Walter M. Hammett
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Doctors' Day	Mrs. William James
Editor, Auxiliary Page, Maryland State Medical Journal	Mrs. Wallace H. Sadowsky
Finance	Mrs. M. McKendree Boyer
Health Careers	Mrs. Thaddeus Elder
Hospitality	Mrs. James L. Garey
<i>Hygeia Filiae</i> —Editor	Mrs. John E. Baybutt
Assoc. Editor	Mrs. Henry E. Langenfelder
International Health Activities	Mrs. Leopoldo Gruss
Legislation	Mrs. Pedro S. DeBorja and Mrs. Albert F. Cooper
Liaison to WASAMA	Mrs. William J. R. Dunseath
Members-at-Large	Mrs. Sergio Alvarez and Mrs. Martin Berger
Membership	Mrs. Marvin L. Kolkin and Mrs. S. G. Sullivan
Mental Health	Mrs. Leslie R. Miles
Press and Publicity	Mrs. Andre V. Fesus
Representative to Med-Chi Public Relations Committee	Mrs. H. Leonard Warres
Revisions and Resolutions	Mrs. John G. Ball
Councilor to Woman's Aux. to Southern Medical Assoc.	Mrs. Archie R. Cohen
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## THE MONTH IN WASHINGTON

The House Ways and Means Committee has approved the Social Security Amendments of 1971 (medicare and medicaid changes) and sent the massive health bill to the floor of the House for expected early passage.

As adopted by the committee, the bill concerns itself with the implementation of the Administration's Health Maintenance Organization option for medicare beneficiaries, restricts physicians' fee increases under federal programs, reduces some long-term medicare benefits, and covers under Medicare for the first time disabled social security beneficiaries.

The Secretary would also be authorized to conduct experiments with areawide or communitywide peer review, utilization review, and medical review mechanisms.

Congress failed to pass substantially the same bill during the last session due to major differences between the House and Senate versions and the lack of time to reach agreement.

Medicare beneficiaries would be permitted to have all covered care provided by a Health Maintenance Organization (HMO), defined as a prepaid group health or other capitation plan, with the government reimbursing the HMO's at 95% of the average cost of medicare beneficiaries in the area.

Physicians' medicare fees

would be pegged at the 75th percentile of actual charges in a locality and future increases would be tied to a special index reflecting rising costs. The Department of Health, Education and Welfare could terminate payments to providers found guilty of program abuses.

A medicare co-insurance factor, one eighth of the hospital deductible, would be applied after the 30th day. The medicare part B deductible would rise to \$60 a year and medically indigent persons above the poverty level could be required by the states to pay an income-related premium.

Other features of the proposed legislation:

—HEW would be required to develop experiments and demonstration projects designed to test payment to providers of services on a prospective basis under the medicare, medicaid, and maternal and child health programs.

—Limits on institutional provider costs to be recognized as reasonable under medicare could be imposed based on comparisons of the costs of covered services by various classes of providers in the same geographical area.

—Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless a bona fide private patient relationship had been established or the hospital

had, in the two-year period ending in 1967, subsequently customarily charged all patients and collected from at least 50% of patients on a fee-for-service basis. Medicare payments could also be authorized on a cost basis for services provided to hospitals by the staff of certain medical schools.

—HEW would be authorized to establish minimum periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to require extended care level of services in an extended care facility. The attending physician would certify to the condition and related need for the services. A similar provision would apply to post-hospital home health services.

—Present penalty provisions relating to the making by providers of care of a false statement or representation of a material fact in any application for medicare payments would be broadened to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral. The penalty for such acts, as well as the acts currently subject to penalty under medicare, would be imprisonment up to one year, a fine of \$10,000, or both. Similar penalty provisions would apply under medicaid.

—HEW would conduct a two-year study of the desirability of covering chiropractors' services under medicare.

The bill allows the HEW Secretary to authorize experiments with methods of medicare reimbursement or payment, "with areawide or communitywide peer review, utilization review, and medical review mechanisms," and with performance incentives for intermediaries and carriers.



Another section of the catch-all bill of wide public interest would establish a new family assistance welfare plan. The bill also increases social security case benefits and taxes.

\* \* \*

**The House Committee on Interstate and Foreign Commerce has approved a three-part health bill designed to meet the national shortage of medical personnel by 1978.**

The proposed legislation would authorize an estimated \$3.3 billion in aid to health profession students and their schools in the next three years and provide the facilities and programs to close the manpower shortages in the health professions within seven years.

The nation's financially beleaguered medical schools would receive \$11,500 for the full-term cost of training each student, an action long urged by the American Medical Association. Saying that the measure was "long overdue," Congressman Paul Rogers (D., Fla.), chairman of the Subcommittee on health, predicts that the legislation will not only solve the shortage of health personnel by 1978, but will provide the necessary groundwork needed if Congress should approve some form of national health insurance.

Under the legislation, expected to pass the house in substantially the same form, each school would receive \$2,500 a student a year for the first three years of training. The grant rises to \$4,000 for the final year. In order to encourage swifter training, three-year schools would receive the same total as four-year schools, but the final year figure would be \$6,500.

Each school must enroll an additional 5% of students, or 10%, whichever is the greater, to qualify for assistance. An extra \$1,000 will be awarded

schools for each student exceeding this total. The measure will also help establish at least five new medical colleges.

Additional authorizations would provide \$270 million for health manpower initiative awards to establish health education centers, and \$412 million for special project grants for programs in family medicine, physician assistant training, and others. The bill continues support for scholarship and student loans at increased levels.

An Internal Revenue Service survey of 8,400 health care providers who participated during 1968 in medicare and medicaid, including physicians and dentists, revealed that 83% reported their receipts correctly.

Fifteen percent of all taxpayers in the study under-reported receipts by an average of \$7,700, according to the IRS, and 2% over-reported, by an average of \$16,000.

The survey was mainly based on providers of care who as individuals received \$25,000 or more from federal programs. Some 15,000 providers were involved in the study, however the 8,400 studied in detail were selected by a "scientific sampling process," the IRS said.

Forty-seven cases have been referred to the intelligence division for preliminary or full scale tax fraud investigation. However, the IRS spokesman pointed out that these results do not necessarily hold true for the entire health care profession.

\* \* \*

**The Justice Department has cracked down on the widespread abuse of "pep pills" by proposing the reclassification of amphetamines and methamphetamines so as to require that they fall in the category of non-refillable prescriptions.**

The action would regulate amphetamines and methamphetamines as narcotic substances

such as morphine, codeine, and opium as they carry a potential for "severe psychological dependence" with "serious danger" to abusers.

Manufacturing quotas geared to estimated legitimate use and the filing by manufacturers of order forms would be required. However, at least one major manufacturer has endorsed the proposal.

Some lawmakers have complained that Justice did not go far enough and that the order should have included phenmetrazine (*Preludin*) and methylphenidate (*Ritalin*).

\* \* \*

**Commenting on the appointment of Merlin K. Duval, MD, by President Nixon as Assistant Secretary of Health and Scientific Affairs, Department of Health, Education and Welfare, American Medical Association President Walter Bornemeier, MD, said the AMA "enthusiastically endorses" the selection.**

Dean of the University of Arizona College of Medicine and former professor of surgery, Dr. Duval, 48, succeeds Roger Egeberg, MD, who remains as a consultant on health at the White House and as a special assistant to the HEW Secretary.

Dr. Duval is a member of the AMA's Committee on Undergraduate Medical Education and the Liaison Committee on Medical Education. A graduate of Dartmouth College and Cornell University Medical School (1946), he is a board certified surgeon.

\* \* \*

**President Nixon recently signed into law a \$6.9 billion supplemental appropriation bill containing an additional \$100 million for cancer research. The "cancer cure" program would have an independently budgeted research unit within the National**



**Institute of Health with a director reporting directly to the President.**

"As I have said before the time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dread disease," Nixon said in a statement.

Elliot Richardson, Secretary of Health, Education and Welfare, commenting on the President's action remarked:

"I might just say briefly that what has been recognized here is the need for and the opportunity for a degree of the kind of managerial focus that has been effective in marshaling resources in other fields."

"There is a distinction, of course, as the President pointed out in his health message and elsewhere, between this situation and the moon shot in the sense that there is a need and an op-

portunity for the development of new knowledge. But at the same time . . . there is an opportunity also for the exercise of a central directive authority particularly in those aspects of the work that can be targeted and handled by contract, rather than grants with individual scientists."

\* \* \*

**Social Security Commissioner Robert Ball in a recent address on the concept of Health Maintenance Organizations, listed six conditions that he considered essential to their success.** The first condition, in Mr. Ball's estimation, was that "this way of practicing medicine must be made attractive to large numbers of physicians."

In elaborating on this point, Mr. Ball said:

"Successful organizations of any kind depend upon high staff morale. Thus, no health care system will work well that is

not reasonably satisfactory to the key profession in that system. Physicians must be attracted to health maintenance organizations and they must feel good about what they are doing. High physician morale is by no means solely a matter of adequate compensation, although adequate compensation is important. The physician must be convinced of his ability to practice good medicine and to be generally free of bureaucratic constraint on professional judgment. Incidentally, it seems strange to me that the matter of physicians likes and dislikes are so frequently overlooked by health care planners. We worry a lot about the morale of the armed forces, of school teachers and other government employees; in the health care system we better worry about the morale of the providers of care."

\* \* \*

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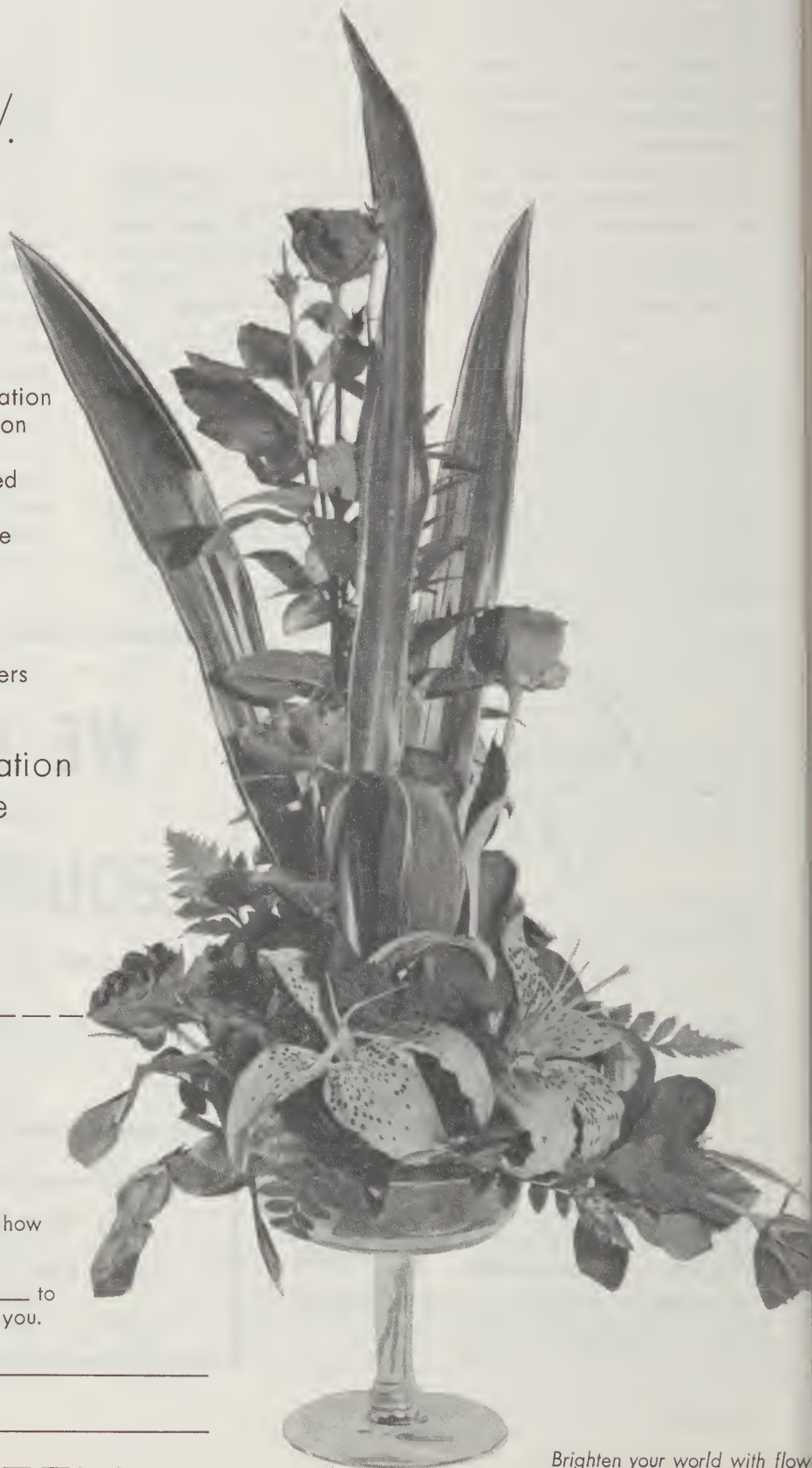
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## library

# "PVs," or Pamphlet Volumes

In many libraries, thousands of scarce or unique pamphlets (mostly less than 100 pages in length, sometimes only a broadside of one leaf) have been bound together in single volumes by earlier collectors or librarians. Often they are pamphlets classified together for subject relevance, or perhaps they are the work or reports of a single author or institution.

Usually binding has done no great damage to these materials, but today it is not considered the best treatment for pamphlets because in the binding process experience shows that the binder's knife has frequently trimmed into the text or sometimes destroyed valuable personal signatures or other useful marks of previous ownership (factors than can be of significant importance in the matter of rare items). Of more usual consideration is the fact that a call for the use or circulation of one item in a pamphlet volume makes all others unavailable to another possible reader.

Libraries no longer handle pamphlets or other ephemeral material in this way. Instead, pamphlets are preserved in their original dress if possible. Generally, they are classified or otherwise arranged according to some system that provides for easy access, and they are kept in specially designed "pamphlet boxes" (there is a variety of types on the market), or in vertical files. For their better preservation the vertical file folders that they come in contact with should be made of acid-free paper stock. Sometimes, in the case of more valuable or fragile pieces, these are further protected by having their own individual acid-free paper envelopes.

Usually, as in Med-Chi's Library, the old pamphlet volumes are not in any classed or subject groupings, so that one volume may contain a number of items, none of which is related to one another in any way at all—author, date, or subject—though of course none will be of a later date than the time the volume was bound.

It is generally not desirable to "disbind" or dismember pamphlet volumes because, unless the work is undertaken with considerable skill, even further damage can be done to any or all pieces in the book. Furthermore, of course, if the items have been catalogued, the catalogue reference notation for each piece will refer to the original pamphlet volume number, a citation that will no longer be valid when the book is taken apart, which means the additional cost of time and revision in the catalogue records.

In the case of numerous volumes at Med-Chi, nevertheless, *some* disbinding is recommended, usually for one of three reasons: first, since many items in pamphlet volumes are not catalogued at all they can, at this time, be properly classified, catalogued, and better preserved; second, because sample checking has shown very poor and inaccurate cataloguing of some pieces which must be corrected; and third, because there is a multiplicity of unnecessary duplicates throughout the pamphlet volumes already otherwise separately catalogued elsewhere in the collection. These duplicates or out-of-scope items can, in many cases, be put into the auction market because they are salable by reason of their subject interest, or because they are by collected authors, such as Sir William Osler for example—the latter sometimes present in numerous reprints of many of his separate publications.

A few other examples will be interesting: one volume ("Medical Pamphlets I") contains eight papers, by John Redman Coxe (1835), William Ingalls (1837), C. J. Buchanan (1839), Martyn Paine (1841), Sir Anthony Carlisle (1829), Robley Dunglison (1837), Edward Warren (1832), and J. C. Cross (1835)—all important or interesting contributions to medicine or medical history. Indeed, the Coxe piece is his famous defense against the calumnious attacks upon him at the University of Pennsylvania, and the Buchanan pamphlet concerns the



Opinion of the Court of Appeals of Maryland in the Case of the University of Maryland, the Med-Chi, and others, a matter of real importance to the study of medical supervision and education in the State. But the point to be made here is that we have identified duplicates of several of these pamphlets, in other volumes or as "separates" in the Library, and Med-Chi recognizes its obligation to make them available to other scholars or libraries if duplicates are not needed.

One interesting pamphlet volume certainly will not be disbound. In an unobtrusive volume marked "Theses—1767-8-I" we have found a remarkable collection of eleven dissertations by the classmates of Gustavus R. Brown (an early Maryland inocu-

lator of Charles County) at the University of Edinburgh, published in 1767 and 1768. Not only is Brown's own dissertation present, *De Ortu Animalium Caloris*, but so are those of George Steptoe of Virginia, Isaac Chanler "Americanus", and the extremely rare *De Coctione Ciborum in Ventriculo*, with a presentation inscription from its author, Benjamin Rush! Incidentally, this was one of our project's important discoveries since the pamphlet volume was not analyzed and the separate dissertations were not previously recorded as being in the Library's collections.

Lee Ash  
Library Consultant

\* \* \*

A few copies of *Early Medicine in Maryland*, by Thomas S. Cullen, an address by the well known president of the Med-Chi in 1927, are available from the Med-Chi Library. The address, illustrated with

portraits, is 15 pages long. All copies are bound in boards, slightly worn, but fine internally. While they last, \$3, postage-free, cash with order. Make checks payable to the Med-Chi Library.

## NEW ACCESSIONS—BOOKS

(Arranged by Authors and Titles)

**Annual review of medicine.** Vol. 22, 1971. Stanford, Calif. Annual Reviews. W 1 AN 6.

Association of American Medical Colleges.

**Admission requirements of American medical colleges, including Canada.** Evanston, Ill. Ref. W 19 A7 1971.

**Current diagnosis and treatment.** Los Altos, Calif., Lange Medical Publications. WB 141 C8 1971.

Gable, Fred B.

**Opportunities in pharmacy careers.** New York, Educational Books Division of Universal Pub. and Distributing Corp. QV 21 G2 1969.

Koch, Richard

**The mentally retarded child and his family.** Edited by Richard Koch and James C. Dobson. New York, Brunner/Mazel. WS 107 K6 1970.

**Operative surgery, vol. 14: Neurosurgery.** 2d ed. Edited by Charles Rob and Rodney Smith. Philadelphia, Lippincott. WO 100 06 1971.

**Physicians' desk reference to pharmaceutical specialties and biologicals.** Rutherford, N.J., Medical Economics, 1971. Ref. QV 738 P4 1971.

**Vitamins and hormones.** Advances in research and application. Vol. 28. New York, Academic Press, Inc. WK 100 V5 1971.

**The Year book of dentistry.** Chicago, Year Book Medical Publishers. WU 100 Y4 1971.

**The Year book of the ear, nose and throat.** Chicago, Year Book Medical Publishers. WV 100 Y4 1971.

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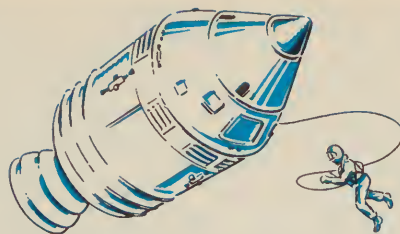
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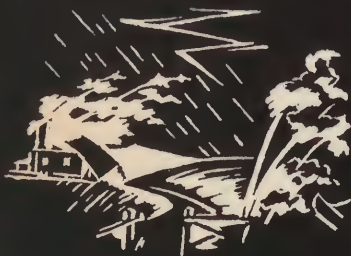
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**Baltimore City Medical Society**

**W**e live in a period of rapid social evolution. Medical training and medical care delivery have been objects of scrutiny and criticism by government agencies, consumers, some physicians, academicians, and medical students. The Board of Directors of the Baltimore City Medical Society is acutely aware of the Society's potential contributing role in solving some of the evolving questions. The meetings of 1971 have been constructed around consideration of sociomedical problems.

At the February 5th meeting, four medical students from the University of Maryland and The Johns Hopkins University medical schools spoke on those aspects of medicine that concerned them most. They represent many asking for "relevance" and "immediate satisfaction". Their remarks elicited a prolonged discussion among the audience. The comments of these four astute young students were considered of sufficient interest to warrant a larger audience. Whether one agrees or disagrees with them, the attitudes reflected here will have formative influences on American medicine of the future.



"The clinical teaching of medicine in our medical schools is spotty at best, fragmented, uneven, discontinuous, and haphazard".<sup>1</sup> These are not the words of a fuzzy-headed student radical, but those of the President of the Massachusetts General Hospital.

# *Medical Education*

## *in the 70's:*

### *What the Student Wants*

**THEODORE G. ROSE**  
Senior, Chairman, Medical Student Society,  
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#### **The Doors of Medical School**

It is evident that students and faculty alike realize that the time-honored systems of medical education which still exist in our medical schools are inadequate and inappropriate for the needs of the student of the 70's and the demands of the public at large in the coming decades. Where shall we make our changes, and how may we act?

First, we must go back to the student's preparation for medical school: his years in college as an under-

graduate. Medical schools must make diversity of scholastic background the rule rather than the exception. At the present time, science majors are actively wooed, while those who have studied arts or music are shunted aside. One must bear in mind that a good physician is a complete physician, and not merely a physical chemist. Furthermore, mindless competition for grades must be eliminated and the individual's progress assessed by frequent per-



sonal evaluation of both knowledge accumulated and ability to reason with that knowledge.

Now let us leave the college campus and arrive eagerly at the doors of medical school itself. We are greeted, not by a sick patient, but by a group of biochemists teaching us that the human body is a mere bag of enzymes and chemical reactions to be memorized. During the next few months in anatomy class we learn that the body is composed of a myriad of minute structures that can be defined by size, shape, and position; but we hear nothing of the diseases which affect these structures. It is not until late in the second year that the student is finally able to speak with a "live" patient. It is essential that the incoming student be taken over to the hospital itself on the very first day of his medical education. He should there be presented with a patient whom he can observe and become acquainted with in the coming months. In this manner, the abstract equations and structures from the classroom become alive and real to the student.

As we advance to the clinical years we meet the king and queen of clinical medicine: the rotation on the medical ward and on the surgical service. On the medical ward the student is told he is a "clinical clerk" and that he, along with the house staff, will perform vital investigations and make crucial decisions upon which the patient's life will depend. In actuality, the student finds he is little more than a lab technician with a college degree. He spends hours doing "scut" on "his" patients on the assurance that it is a "learning experience". Teaching is at a minimum; the intern, with whom the student spends nearly all his time, is simply too overworked, and senior house staff, although generally helpful, are occasionally uninterested and, rarely, actively avoid students and the responsibility of teaching.

On the surgery service the student is told, "Stick around, you might learn something." Here again, however, the student is given many mindless duties to perform with little reward in personal responsibility. It is common knowledge that the student who gains the most from a case is not the one who scrubs and holds a retractor for six hours at the far end of the table, but the student who reads about the operation beforehand, is present and in good position to observe during the crucial hour or two of the operation, and then retires to the library for more in-depth reading. It is a rare surgeon who takes the time and has the concern to tell the student exactly what he is doing and why.

## Community Medicine

An area that is conspicuous by its absence in both clinical medicine and surgery is experience in community medicine. The private physician is referred to as the "LMD2" and is often viewed as a misinformed buffoon writing inappropriate prescriptions and missing "easy" diagnoses. It is essential that the student be given actual experience in the local practice of medicine and a firsthand education in what it is like to have a private office. Such a program could easily be grafted onto current clerkships in medicine and surgery.

If we now consider the four years of medical school as a whole, there are two items which we must examine closely: cost, and grading systems. Tuition at one of the leading medical schools will exceed \$3,000 in the coming year. With scholarship funds shrinking rapidly, the profession of medicine will again become an endeavor for only the wealthy and the sons of the wealthy. We must never allow this; the cost to the patient and the profession will be all too dear.

A grading system based solely on the time-honored written examination has no place in the medical curricula of today. Frequent, exhaustive oral examinations in actual clinical situations are essential. Observation of the student's interaction with the patient, performance of the physical exam, and reasoning with the data accumulated must be frequently tested, corrected, and tested again. Only in this manner will the student achieve excellence as a historian, examiner, and diagnostician.

In conclusion, I wish to present four proposals which I believe are loudly called for by medical education today:

1. A curriculum plan which integrates the basic sciences and clinical services such that the student is never divorced from his subject, the patient.
2. A house staff selection procedure which requires willingness to teach as a prerequisite for a position at a university hospital.
3. Increased governmental and private funds to aid medical schools and for scholarships and long-term, low-interest loans for students.
4. A program in which the student is sent into the community to work with a private physician in his office and to observe the practice of community medicine.

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## REFERENCE

1. Knowles, John H.M.D.: "The Balanced Biology of the Teaching Hospital." *NEJN*, Aug. 22-29, 1963. Quoted in *The Doctors* by Martin L. Gross. pg. 436, Dell pub.



# THE PEOPLE'S FREE MEDICAL CLINIC

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**The People's Free Medical Clinic is a primary health-care facility conceived at the community level and developed largely by nonhealth professionals concerned about the expense and inadequacy of health care in an urban setting.**

The clinic is located in the Waverly area of Baltimore at 3028 Greenmount Avenue. It opened last spring as the culmination of efforts of members from two organizations: the Baltimore Defense Committee and Baltimore Women's Liberation. These people, after contacting and working with interested professionals, raised the necessary finances and worked out a plan for operation.

Money for operating the clinic, which now has a monthly budget of around \$1,500, comes, by and large, from pledged monthly contributions, most of which are less than \$5 per month, and over 75% of which come from the area surrounding the clinic. Several large contributions have been received including one for \$1,500 from the Presbytery of Baltimore and one for \$3,000 from the student council at the University of Maryland Medical School that donated their entire social budget.

## **What the Clinic Offers**

At present the clinic is open three evenings a week for the provision of medical services and various types of counseling. Medical services include general medical plus specialties such as Ob-Gyn, ENT, pediatrics, and psychiatry. The counseling includes women's counseling in the areas of birth control and abortion, and mental health counseling including the area of drug abuse. In addition, the clinic provides child care services for patients waiting to be seen. The medical services are supported by a lab equipped to do routine analyses on blood and urine, and vaginal smears. Other tests, including the STS, are done by the state labs, and a private medical group provides blood chemistries.

## **Operating Routine**

When a patient comes into the clinic, he signs in with a receptionist who prepares a history folder if this is the patient's first visit, or pulls his history from the file if he has been to the clinic before. The receptionist then introduces the patient to a health advocate, a community member or student, who acts to coordinate and explain such counseling or medical care, or both, that the patient may require. The advocate is also responsible for follow-up on the patient, and is particularly useful in helping the patient arrange any studies which cannot be done at the clinic, such as X-rays. The advocate also makes certain that the patient, if eligible, is signed up for medical assistance. The advocate finds out why the person has come to the clinic and then arranges for him to see the appropriate people. Often these may be people in several areas. A woman coming to the clinic to inquire about contraception is seen both by women's counselors and a physician or nurse-midwife. A person coming to the clinic with a health problem related to drug abuse can be seen by both a physician and a drug counselor. Before any patient is seen by a physician a nurse takes his vital signs and records them in the patient's folder. After seeing the physician in a private examining room, the patient returns to the advocate who, with the assistance of the nurse or physician, makes certain that the patient understands his treatment plan. If the patient requires a return visit, the advocate stresses its importance and explains that if the patient returns on the same day of the week he will be seen by the same physician.



The clinic is also open every weekday from noon to 5 PM. No medical services are provided at this time, but the day staff does necessary follow-up in cooperation with the advocates and also disseminates a wide range of community information not restricted to health but including many aspects of available social services.

The staff of the clinic is all volunteer except for two coordinators who are paid a subsistence wage of \$30 a week each. Over half the staff members come from the immediate area. The physicians include house officers from the city's various hospitals, private practitioners, and officers in the Public Health Service. Most staff members donate one evening a week, although some from specialties which are not heavily utilized are scheduled only once a month. The clinic provides malpractice coverage.

As of January 31, the clinic saw 1,926 people, making a total of 3,507 visits. This includes 436 visits for infectious disease (counting upper respiratory infections), 308 for venereal disease, 370 for

gynecological reasons, 282 for women's counseling, 269 for pediatric problems, 193 for mental health counseling, and 1 for vasectomy (vasectomies were initiated in January; the clinic is currently doing about one a week).

#### Newsletter

In addition to the activities already described, the clinic publishes a monthly paper, *The Newsletter*, which reports on all programs and deals with health related issues in the city. The clinic will be happy to add anyone to the mailing list, particularly if their request is accompanied by a pledge or contribution.

Although the actual services provided by the clinic will never make a very large dent in the health problems of Baltimore, the People's Free Medical Clinic can and does play an important role in exploring methods for using paraprofessionals, delivering integrated and personalized medical and counseling services, and delivering these services without cost barrier.

# The Changing Attitudes of Medical Education and Its Ramifications Upon the Student

There is a rising tide of feeling that medical education in all its phases is not keeping pace with the wants and needs of the population it strives to serve, and the students it strives to teach. The traditionally conservative medical student is now showing increasing concern for the world outside the laboratory, the classroom, and the hospital. The students and the community are both very much concerned with a changing role for the Medical School and the University Medical Center.

**HOWARD WEINSTEIN**  
President, Junior Class  
University of Maryland School of Medicine  
Baltimore



Many schools are beginning to accept the role of the University Medical Center as a key community resource, but medical education continues to approach the problems of sick people from the perspective of biological science. The social environment surrounding the sick person and its effects on the causation or course of disease, or both, is virtually unknown.

### Redefinition

In attempting to expand and redefine the purposes of medical education one must assess the interests of the medical students being selected by the admissions committees, reevaluate the structure and content of the curriculum, the goals of the training period, the teaching methodology, and the needs of the community. Much of what happens to the medical student depends not only on what he brings with him to medical school, but on what the institution offers him and asks of him.

What kinds of interests do medical students have at the time of matriculation, and has there been a significant change in the last decade? Dr. Daniel Funkenstein, Professor of Psychiatry at Harvard Medical School, has been giving the Strong Vocational Interest Test to entering Harvard Medical Students for many years. Maryland Medical School has given this test to entering students for the past two years. The test categorizes students into four interest groups: science, people, human behavior, and a null group.

	1973		1974
	Maryland	Harvard	Maryland
Science	17%	39%	26%
People	29%	39%	19%
Human behavior	39%	51%	48%

The pattern has been shifting during the past few years from an interest in science to a stronger interest in human behavior. This is being reflected by the number of students choosing psychiatry as a career, and the recent interest in community and family medicine.

Today's medical students are not alike in their previous experience, motivation, or in future goals. To assume that a highly individualistic person will perform optimally in a rigid training program is not realistic. The successes the student has will be achieved in spite of, rather than because of his formal teaching.

### Self Expression

Medical schools are attempting to give an opportunity for self expression and individualistic growth by allowing for an elective program during the senior year. I see this as a step in the right direction, but not an end in itself. The concept of a multitrack

curriculum has been proposed in which a student, at an early point in his medical education, could choose a path which would fulfill his interests and allow for his individualistic growth. But how much flexibility and early specialization is desirable, and can these be exclusive of each other to some extent? Is the goal of medical education to train a group of students to become physicians by using the same blueprint for each individual, or to offer a core amount of material to all students and then allow for personal development according to their unique interests and goals, ie, multitrack curriculum? These questions must be answered before one can structure a medical school curriculum.

Students are also asking for improvements in the delivery of health care to the poor, the aged, and the black, and are making contacts with these people as individuals in the community rather than only as patients in clinical teaching situations. This new breed, the intelligent, compassionate, and committed student activist in medical school, is asking for emphasis to be placed on drug addiction, alcoholism, venereal disease, overpopulation, and action on social and environmental factors that breed disease and impede health.

### Medical Schools' Response

In response to these student interests and community needs, medical schools are beginning to initiate new teaching programs. An urban preceptorship program has been developed by Quentin Young, MD, at Illinois Medical School, which is an attempt at an educational alternative sensitive to the widespread criticism of contemporary medical education as being parochial and socially unconscious. The program consists of a three-week seminar course in which a given day might consist of a visit by the Commissioner of Health of Chicago, followed by a board member from the local neighborhood center, and the afternoon might be devoted to a symposium involving a medical care economist, an epidemiologist, and a practicing pediatrician from the private sector of the ghetto. For the next ten weeks the students do field work in areas that interest them. The University of Maryland has established an Ambulatory Care Program which shares many of the goals of Dr. Young's program. These programs are allowing contact with people as individuals rather than only as patients in clinical teaching settings, and also give some insight into the political power structure of the health establishment.

Programs of this nature must be incorporated into medical school curricula as a supplement to and not a replacement for basic clinical teaching. Bed-side teaching is still the most important part of a student's education. There have been studies designed to evaluate student performance in obtaining a complete



history and physical examination, and the data seem to indicate that today's medical students are better at knowing than at doing. At most medical schools there is a lack of direct observation of the student at the bed-side, and in most situations the teacher does the work while the student watches and criticizes. It is the student who must do the work. The student and patient should interact as much as possible. When the patient goes to X-ray for a special study or to surgery, the student should be there. This is only possible with great flexibility in the student's schedule. The student should also be able to follow the patient's progress after discharge from the hospital.

# The New Medical Student

The single most important facet of this responsibility is the medical student's concern that he adequately fulfills his educational needs. In attempting to meet this responsibility, the student feels that it is a function of the medical school to help him pursue a medical education based on the needs of the community he is to serve. However, there are many students who feel that their medical education is deficient in many pertinent areas—particularly social areas—and that the first two years of medical school are merely a period of extended educational adolescence. This means the medical student feels that his medical education is not adequately preparing him for his role as a physician. It is understandable then how this causes a source of tension for the student, which hinders his working relationship with the medical school. Hence, I feel that both the medical students and medical school must remedy this situation by being intellectually honest

The student-patient relationship must extend beyond the role of the patient as teaching material. It must be a human relationship that is mutually beneficial to the student and the patient. This principle then requires that the student actually has a contribution to make to the patient. The student must serve a worthwhile function on the patient's behalf, by being an integral part of the health care team.

John Knowles, MD, said in a speech delivered at a Medical Education Conference in Chicago in 1969: "It is not too late for the profession to acquire a broader view based on certain changes in its educational process and thereby to assume new responsibilities. The question remains, will it?"

**It is my belief, that the primary responsibility that the medical student feels toward his society is to become a competent physician without sacrificing compassion, empathy, or realistic goals. The medical student feels a responsibility to furnish his community with a physician as well-versed in the pathology of disease as in the psychology of disease—a competence in both the scientific and social spheres. But we feel that before we can become physicians and teachers, as the name implies, we must be able to communicate and interact with the patient on a medical and scientific level, as well as on a humanistic level.**

**PETER D. VASH**  
**Junior**  
**President of Student Council**  
**University of Maryland School of Medicine**

and conscientious enough to provide a system of medical education adequately balanced, without a discrepancy between biological sciences and social sciences.

## **Discrepancy**

This discrepancy reflects the deep gap that exists between medical education and the developmental needs of the medical student. This gap arose because the rapid social changes which are currently taking place have far surpassed the academic developments that are only now beginning to occur within the medical schools. This discrepancy places pressures upon the student, which will, in all probability, intensify with further social changes. These changes are in the areas of the social sciences, and are more of a humanistic than a scientific nature. I think it would be unrealistic for the system of medical education to try to keep pace with the social issues and



cultural changes of today. But I do think it is their responsibility to medical students to be aware of these changes, and be able to offer the student opportunity to further educate himself in those areas toward which these changes are progressing.

Too many groups in the medical community—students, faculty members, private practitioners, and medical school administrators—have tended to attribute our current difficulties to one another. The whole process of making such mutual accusations are as destructive as they are a waste of time. It should be evident to all concerned that the difficulties we are encountering are not so much due to the failure of one or another group, but rather due to a differential change of pace between social issues and medical schools. Above all, I feel that this is a time for positive action, not passing the buck.

### **The University of Maryland**

For example, I believe that the University of Maryland has the right idea by offering freshmen the opportunity to participate in a psychiatry program—one different from the course taken by the rest of the class—which involves earlier patient contact with close supervision, and the discussion of psychiatric principles which relate to the patient seen. I also feel that this is a progressive sign that we are given the opportunity and responsibility of determining our fourth year rotation by means of Maryland's senior year elective program. This allows the student the opportunity to further educate himself in those areas where he may feel it necessary or desirable. The medical school, realizing that frustrations and discontent arise because the student is often an intrinsic part of, and deeply involved in the ongoing changes, might remedy this by offering at least some social sciences the first two years. I think that an elective course in, for example, advanced biochemistry, biostatistics, medical sociology or psychology, might be a worthwhile consideration. I felt the most valuable teaching program at the University of Maryland was that which tried to correlate the clinical, pathological, psychological, and social factors of the patient's disease process. I would hope that the medical school will further emphasize programs of this nature. Finally, I feel that there are topics being presented within the first two years that are too highly specialized for the student and are detracting from needed emphasis on the more common disease processes that make up a large part of today's medical problem, such as alcoholism, drugs, and mental illness.

### **Social Responsibility**

Medical students feel that the social responsibility of the physicians should be in three major areas:

(1) The delivery of medical care to all segments

of society based on need rather than finances;

(2) The social factors that breed disease and impede health must be eliminated; and

(3) Medical education of minority group students must be vigorously pursued. Hence, we feel that we could better learn and prepare for our role as a physician if we were given more exposure to such areas as these. Thus, for instance, in the first two years, with earlier exposure to patient care and increased contact with faculty and not the products of faculty research, the student would learn more about the delivery of health care first hand, while also becoming more familiar with the physician's role. We would like to learn more about the emotional, social, and family aspects of medical care of the individual patient, and burden ourselves less with research-oriented work that a great majority of us will never pursue.

As Daniel Funkenstein of the Harvard Medical School pointed out, it is ironic that in areas where medical students are the most socially active, medical schools have not shown much concern, and where medical students show signs of becoming socially irresponsible, medical schools are most active. The medical student would like to be a part of increased community action, and desires to enter the art of medicine through the study of the more common disease processes of the community, rather than through pursuing research projects.

### **Overeducation**

To overeducate the student with material of little concern to him and less value to the community is a waste of educational resources. In addition, a system of medical education which encourages highly competitive individualism rather than working as a cooperative team has little positive value for the practice of medicine today, not to speak of tomorrow. The medical school curriculum is oriented to help students become very competent biologically oriented scientists, and it is superb in this aspect of its education. But it is deficient in teaching the emotional, social, and family aspects of medical care.

Yet, these are the very concepts that the medical student must somehow learn if he is to ever hope of truly becoming a physician of the community and successfully meeting his responsibilities. If medical schools shifted some of their attention from strictly academic considerations such as grades, and examinations, important as they are, to the broader question of the school's educational climate, they then might dispel the disruptive pressures which so hinder the medical student. Thus, medical schools would encourage the student to express his responsibility to the community, and graduate physicians not only with great technological skills, but with the maturity to use them wisely.



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A revealing picture of child abuse patterns is

provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

**\*For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcoming issues will be the history of birth control, the influence of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.



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**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,2</sup> leading to this conclusion, and one<sup>3</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>1</sup> was about sevenfold, while Sartwell and associates<sup>3</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of

them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2: 193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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# ANNUAL REPORTS TO THE HOUSE OF DELEGATES

*Mr. President and Members of the House of Delegates:*

The following committees held no meetings during the year and have no reports to make:

Committee on Contractural Arrangements  
Medical Annals of Maryland  
Medical Emergency Disaster Service Committee (no committee appointed during the year)  
Student American Medical Association

(The Maryland Medical Political Action Committee will have a report in a forthcoming issue of the Journal.)

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## COUNCIL AND EXECUTIVE COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Council held nine regular sessions during the past year, plus one special session. In addition, the Executive Committee met on 12 different occasions.

The Council is charged under the Bylaws with having:

"... all power and authority over the affairs of the House of Delegates, except that of modifying any action taken by the House of Delegates . . ."  
(Article VII, Section 2)

However, lest there be any question, let me unhesitatingly state that the Council would, if considered necessary, call the House of Delegates into special ses-

sion, to consider any matter of sufficient importance, which needed the support of the House.

Some of the highlights of the Council's activity are listed below. As has been the custom for some time, the Council and Executive Committee actions in summary form are all reported in the *Maryland State Medical Journal* for the information of the entire membership.

- Discussed at considerable length, recommendations of the AMA's Long Range Committee on Planning, which had been evaluated by the Faculty's Policy and Planning Committee. The decisions of the Council were communicated to the Faculty's Delegates to the AMA House of Delegates.



- At the request of the AFL/CIO's Health Care Committee, named a special group to meet with representatives of the AFL/CIO to discuss health care delivery and costs within the community.
- Heard and approved, with reluctance, a proposed rate increase for Professional Liability Insurance with the St. Paul Companies, effective July 1, 1970.
- Authorized employment of a consulting actuary to analyze the figures on professional liability insurance presented by St. Paul.
- Authorized a study of professional liability incidence in Maryland for the past ten years.
- Approved of chairmen of four representative Faculty committees to meet with the Maryland Blue Shield board to discuss mutual problems.
- Approved various recommendations in connection with implementation of Peer Review activities throughout the state, all at the request of the Faculty's Peer Review committee.
- Approved the development (later implemented) of a car-rental program for Faculty members.
- Authorized legal action against the use of the term "Chiropractic Physician" by chiropractors, which misleads the public.
- Heard discussed in a special session the pros and cons of various legislative proposals at the federal level dealing with National Health Insurance.
- Made various appointments or recommendations for appointment to different committees, commissions, or panels.
- Met jointly with the Maryland State Dental Association Executive Committee; and the Maryland Hospital Association Executive Committee.
- Endorsed various scientific and statistical studies, urging the membership to cooperate if asked to do so.

The above is only a brief summary of more important activities. It is pointed out that approval was given to a variety of committee recommendations, details of which will be found in the various individual committee reports to the House of Delegates.

The Council recommends Emeritus Membership be granted at the request of the group indicated to the following:

Louis C. Dobihal, MD, Baltimore	(Baltimore City)
R. Walter Graham, MD, Baltimore	(Baltimore City)
Sigmund R. Nowak, MD, Baltimore	(Baltimore City)
Alexander Weinstock, MD, Baltimore	(Baltimore City)
Caroline A. Chandler, MD, Glen Arm	(Executive Committee)
Ilse Kamm, MD, Sykesville	(Carroll County)

Respectfully submitted,  
MANNING W. ALDEN, MD, *Chairman*

## SECRETARY

*Mr. President and Members of the House of Delegates:*

The Secretary's official responsibility includes the efficient operation of the Faculty office and, in particular, maintenance of all membership records, staffing of committees, councils, and the House of Delegates. While it would physically be impossible to attend all

committee meetings, the Secretary is kept informed of this activity by receiving copies of all subcommittee and committee minutes. These are read carefully so as to be fully aware of what is taking place within the Faculty structure. The results of all of this can be found in the voluminous and well-documented activities contained in various committee reports.

All meetings of the Executive Committee, Council, and House of Delegates have been attended by the Secretary.

Respectfully submitted,  
WILLIAM A. PILLSBURY, MD, *Secretary*

## EXECUTIVE DIRECTOR

*Mr. President and Members of the House of Delegates:*

This annual meeting marks the completion of my 13th year as the Executive Officer of the Medical and Chirurgical Faculty of the State of Maryland. It is my hope the Faculty has benefitted from my services as much as I have enjoyed rendering them.

As medicine faces increasing challenges, so the workload of the staff increases. We endeavor to do our best by staffing, researching, and doing all the things necessary to provide efficient service to committees and other groups of the Faculty.

Expert advice and assistance is available as close as the nearest telephone for all members.

Nearly all component medical societies received a personal visit from the Executive Director during the year. In addition, the various statewide specialty groups were contacted with an offer of attendance at their business sessions. About six of these groups responded and the Faculty's story was taken to them.

The Executive Director attended over 238 meetings of committees, councils, and subcommittees during the past year. In addition, staff personnel attended many of the same sessions, as well as staffing meetings of other such groups.

The legislative activity of the Faculty continues to absorb a considerable amount of the Executive Director's time. Demands placed by state legislators and other governmental officials on advice available from the Faculty places a heavy burden on Faculty and staff.

The Executive Director continues to serve on various special assignments at the request of nonprofit and other health-related or oriented groups. These include the Board of Review, Department of Health and Mental Hygiene; and various subcommittees dealing with health planning.

Respectfully submitted,  
JOHN SARGEANT, *Executive Director*

## BOARD OF MEDICAL EXAMINERS

*Mr. President and Members of the House of Delegates:*

The Board of Medical Examiners is composed of the following members whose terms expire on the dates indicated below:

J. Roy Guyther, MD	1971
Gerald A. Galvin, MD	1971



Karl F. Mech, MD .....	1972
Archie R. Cohen, MD .....	1972
John E. Adams, MD .....	1973
DeWitt E. DeLawter, MD .....	1973
Elmer G. Linhardt, MD .....	1974
William L. Stewart, MD .....	1974

As the terms of J. Roy Guyther, MD, and Gerald A. Galvin, MD, expire June 1971, two members to serve until 1975 are to be elected at the meeting of the Medical and Chirurgical Faculty.

Examinations given during the year show the following results:

Applications received for examination .....	565
Second year students examined and reexamined ..	35
Postponed, withdrawn or did not appear .....	74
Not eligible for license .....	109
Examined in second part of examination .....	44
Complete examination .....	210
Reexamined .....	202
Eligible for license .....	456
Passed—American Graduates .....	104
Passed—Foreign Graduates .....	172
Failed—American Graduates .....	43
Failed—Foreign Graduates .....	137
American graduates who failed are as follows:	
Univ. Maryland—3	
Johns Hopkins Univ.—1	
Univ. Colorado—1	
New York Univ.—1	
Meharry Med. Col.—2	
Howard Univ.—35	
Licenses issued after examination .....	276
Licenses issued by endorsement of National Board Certificate .....	427
Licenses issued by reciprocity with other state licenses .....	222
Total licenses issued .....	925
Licenses revoked .....	1
Licenses suspended .....	0
Licentiates certified to other states .....	341
Copies of licenses issued .....	8
American graduates examined and reexamined ...	147
Foreign graduates examined and reexamined ....	309
Foreign graduates approved for examination ....	271
Written inquiries from foreign graduates (approximately) .....	1,000
Office interviews with foreign graduates (approximately) .....	400
Telephone inquiries from foreign graduates (approximately) .....	1,500
Telephone inquiries concerning registration of physicians .....	3,100
Registration Certificates issued from 1/1/70 to 12/31/70 .....	4,370

#### Licensed by Special Examination

Howard DeWitt Fishburn, MD—May 21, 1970

#### Revocation of Medical License

On June 25, 1970, the license of *George H. Beck, MD*, was revoked by the Commission on Medical Discipline

of Maryland, for violation of Article 43, Section 145 of the Annotated Code of the Public General Laws of Maryland, of addiction to narcotics. This revocation was stayed, and Dr. Beck was placed on probation, upon satisfactory compliance with certain conditions.

On March 13, 1970, the appeal in the case of *Ghulam Mohammad Nasim, MD*, was heard. The court affirmed the findings of the Board of Medical Examiners, revoking the license of Dr. Nasim.

#### Reprimands

**Leonard M. Zullo, MD**, appeared before the Board on April 23, 1970, regarding his practice of medicine, and the practices of Miss Joyce Smith, a psychotherapist working in Dr. Zullo's office. After discussion, the following points were noted: (1) Dr. Zullo presigns prescription blanks for Miss Smith's use. These were used for patients who have been on the same medication for years. It is possible that Dr. Zullo has not seen some of these patients for a year. (2) Dr. Zullo bills patients for services rendered when he had not seen the patient on that particular visit. (3) Miss Smith is practicing medicine in that she sees patients on her own, and issues prescriptions (presigned by Dr. Zullo) to these patients without supervision from Dr. Zullo. It was the unanimous decision of the Board that Dr. Zullo should not use presigned prescriptions. Miss Smith should converse with Dr. Zullo before each patient leaves the office to receive Dr. Zullo's directions. Dr. Zullo is the one to prescribe and if the prescription is to be changed, he is the one to do it. He was told that prestamped prescription blanks (prestamped with the names of drugs and dosage) are not illegal, but the Board felt this was not good practice. Dr. Zullo accepted the recommendations of the Board and stated that he would follow same.

**Dr. Charles Cooper**, a chiropractor, appeared before the Executive Committee of the Board on August 13, 1970, to discuss his practice of medicine without a license. A statement, signed by Dr. Cooper, was presented on which he had diagnosed several conditions. Such diagnoses fall within the province of the medical profession. Dr. Cooper was requested to notify the Board within 30 days that he had ceased and desisted such practice. At the expiration of the 30 days, no correspondence had been received. Therefore, the file was referred to the State's Attorney for Baltimore city for necessary action.

#### Tuberculin Testing

An inquiry was made whether the Board of Medical Examiners would approve the use of health aides in carrying out intradermal tuberculin testing, provided they receive a formal course of instruction in the procedure and providing they work under professional supervision. It was the decision of the Board to approve the use of health aides in carrying out intradermal tuberculin testing, provided they have received a formal course of instruction in the procedure, and provided they work under direct, personal supervision of a licensed physician.

#### Refresher Courses

It is the present policy of the Board not to approve refresher courses given by individual physicians, but



to approve only those given by an official medical educational institution.

#### **Medical Practice Act**

Senate Bill No. 257 was signed by the Governor, creating a new Medical Practice Act, effective July 1, 1970.

#### **FLEX Examination**

It was the decision of the Board of Medical Examiners to implement the FLEX examination for licensure in Maryland, beginning with the December, 1970 examination.

#### **FLEX Test Committee**

Elmer G. Linhardt, MD, was elected to represent the Board of Medical Examiners on the FLEX Test Committee.

#### **Commission on Medical Discipline**

Elmer G. Linhardt, MD, was reelected to serve on the Commission on Medical Discipline of Maryland, as a representative of the Board for a three-year term beginning July 1, 1970.

#### **Triennial Registration**

Upon completion of the current registration period, registration numbers in the future will be assigned on a permanent basis.

#### **Revised Fee Schedule**

Effective August 1, 1970, the following fees were changed:

Complete FLEX examination—\$100

FLEX reexamination—Day I —\$22.50

Day II —\$25.00

Day III—\$52.50

Review fee for foreign credentials—\$15

Certification of records leading to licensure in other states—\$15

Duplicate license—\$25

Temporary Permit—\$25

Certified copy of grades received on examination for licensure—\$5

#### **Requirements for Foreign Medical Graduates**

Effective December 1, 1970, the training requirement for foreign graduates was changed to one year postgraduate training in the United States in accredited training programs.

Reciprocity—(1) A graduate of a foreign medical school is not accepted by reciprocity in Maryland unless he has been licensed, after regular written state board examination, in one of the states or the District of Columbia, for a period of five years, and in reputable practice for the same length of time, which will qualify him for reciprocity, provided all other credentials are satisfactory to the Board. (2) Reciprocity will be granted if the applicant has passed the FLEX examination in another state and has received a weighted average of 75%, provided all other credentials are satisfactory to the Board.

#### **Temporary Permit**

"A temporary permit to practice medicine, without examination, may be issued by the Board to a qualified

physician for the purpose of postgraduate teaching. Such permits may be issued for the period of one year only." The temporary permit may be issued to those physicians of a professorial status. The term "postgraduate teaching" is limited to a medical school and its principal associated hospital, and the term "qualified physician" meaning that such physician is identified to the medical school in a professorial rank (Professor, Clinical Professor, Associate Professor, Assistant Professor).

#### **Sixty-Sixth Annual Congress on Medical Education and Licensure**

Doctors Karl F. Mech, Archie R. Cohen, and Elmer G. Linhardt attended the congress held in Chicago, Illinois, in February 1970.

Respectfully submitted,

ELMER G. LINHARDT, MD, *Executive Secretary*

### **BYLAWS COMMITTEE**

*Mr. President and Members of the House of Delegates:*

The Bylaws Committee has been instructed to present the following Bylaw amendments for your consideration:

1. Amend Article II, Section 4, after the words "greatly limited" and before the words "they shall", by inserting:

"The Council, of its own motion and without the request of a component society, may recommend to the House of Delegates for Emeritus Membership any Affiliate member under the provisions of Article II, Section 3 (2), provided they meet all of the requirements of this section."

This amendment would provide for those members who have no affiliation with a component society to obtain Emeritus Membership. At present, such Emeritus Membership can only be obtained on recommendation of a component society. Frequently, a member will move from the state or component jurisdiction prior to requesting such status.

2. Amend Article XI, Section 19 by striking the entire section and substituting the following new sections:

Section 19. A COMMITTEE ON CONTINUING MEDICAL EDUCATION of at least eight members shall consider and advise upon postgraduate educational programs, all phases of medical education, including hospital educational programs, such as residency training programs. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. Its chairman shall be appointed by the President; with the members of the committee appointed by the chairman, with the approval of the President.

Section 20. A COMMITTEE ON PREVENTIVE MEDICINE AND PUBLIC HEALTH of at least five members shall consider and advise upon all aspects of health maintenance, preventive medicine and public health. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. Its chairman shall be appointed by the President; with the members of the committee appointed by the chairman, with the approval of the President.

This change in the Bylaws is being made at the request of one of the most active committees conducting the largest amount of activity of almost any Faculty group. It will enable more attention to be paid to continuing medical education and will assist the Program and Ar-



rangements Committee in developing educational programs for presentation to the members and others in the medical fields.

As more and more attention is being focused on health maintenance and preventive medicine, it is important that the Faculty play an important and emerging role in this area. Separation of these two functions will enable more attention to be paid to these areas, both separately and collectively.

3. Amend Article III, Section 1 (a) by substituting for it the following:

"(a) *For Active Members:* \$45 for the first year in private practice; \$55 for the second year in private practice; \$95 annually thereafter."

This amendment will take effect in the 1972 dues year and thereafter.

The Executive Committee requested the Bylaws Committee to prepare the above Bylaw amendment providing for the dues increase shown. All delegates are aware of the budget deficit projected for the 1971 calendar year. In addition, a deficit for 1970 was incurred. Both of these deficits can be underwritten from the surplus accumulated in past years.

Dues were increased last in 1964. Since that date, the cost of living has jumped more than the percentage accounted for above. As the cost of living has risen, so have Faculty expenses in all categories.

A typical example of budget figures for 1971 and 1964 are as follows:

	1964	1971
Legal Fees	3,000	10,000
Utilities	6,500	7,500
Postage, Telephone, etc.	8,500	13,500

State society dues vary from a low of \$35 in Massachusetts to a high of \$200 in Alaska. States comparable to Maryland include North Carolina, where dues are \$95; Minnesota, \$100; Indiana, \$90; and Louisiana, \$85. Colorado's dues are \$130; South Dakota's, \$125.

While the value of the dollar declines, medicine is required to spend more and more for increased activities. New and uncharted fields are being opened up by the Faculty—peer review, the Commission on Medical Discipline, use of paramedical personnel, legislation, malpractice studies, and countless other areas are being probed and analyzed in an attempt to improve the quality of health care delivered to the public and, at the same time, to keep members fully informed and aware of the trends in the medical field.

Respectfully submitted,

CHARLES F. O'DONNELL, MD, *Chairman*  
ARTHUR E. COCCO, MD  
DEWITT E. DELAWTER, MD  
VINCENT J. FIOCCO, JR., MD

## CURATOR

*Mr. President and Members of the House of Delegates:*

In accordance with standing policy in this regard, portrait restoration continued this year for a total ex-

pense of \$500. This conforms with action taken by the House of Delegates several years ago.

During the year, several items were added to our collection of memorabilia. We are indebted to all those who think of us when they have items of historical interest that can be preserved for posterity. The list of items that have been received during the past 12 months includes:

Two instrument cases, one containing a saw and several knives, the other a set of amputation instruments, received from John E. Savage, MD, of Baltimore. They were the property of his cousin, Luther Ross, MD, who practiced in rural Philadelphia in the 1880's.

A microscope and two books—*National Dispensatory*, 2d ed. 1880, and Austin Flint's *Practice of Medicine*, 2d ed. 1866—donated by Mr. Elting C. Stillwell, of Baltimore.

A pocket case containing a folding syringe and small vials of morphine and atropine. These items were donated by Ernest H. Hinrichs, DDS, of Ruxton, and belonged to Dr. Hinrich's grandfather, who was also a dentist.

Perhaps the most interesting development that has occurred during this period of time is that the Smithsonian Institute is now developing a section on the History of Medicine. As a result, a photographic record has been made of all items in our collection for the Institute's archives. In addition, that group has offered to store and preserve many items of interest, for which the Faculty has limited space.

It is also understood that an exhibit will be developed with items from our collection being used as the highlight or focal point of the exhibit. Plans for this are currently being developed.

Approval for both of these requests has been given by the Council.

Respectfully submitted,

E. DAVID WEINBERG, MD, *Curator*

## DELEGATES TO THE AMA HOUSE OF DELEGATES

JUNE 21-25, 1970  
CHICAGO

*Mr. President and Members of the House of Delegates:*

The three Delegates and Senior Alternate Delegate attended the AMA House of Delegates sessions in Chicago, Illinois, June 21-25, 1970. In addition, M. McKendree Boyer, MD, of Damascus, Md., also attended these sessions at his own expense. Dr. Boyer is second alternate delegate. J. Sheldon Eastland, MD, was named a member of Reference Committee B.

As is the custom, your Delegates, Alternate Delegates, and Executive Director were assigned to various Reference Committee hearings to monitor the discussion that took place and to bring back comments and suggestions to the Maryland delegation for its consideration, prior to each House of Delegates session.

A summary of the actions taken follows. (A more complete report on the actions taken at this meeting



can be found in the minutes of the meeting which will be published in a forthcoming issue of *JAMA*.)

## HOUSE ACTIONS

From June 21 through June 25, the House was in business sessions for 17 hours and 15 minutes, during which it considered a record 201 items of business. Included were 61 reports—31 from the Board; 3 from the Judicial Council; 6 from the Council on Constitution and Bylaws; 10 from the Council on Medical Education; 5 from the Council on Medical Service; and 6 special reports. It also dealt with 140 resolutions—8 unnumbered memorial or commendatory ones; 27 special ones generated by the (Himmler) Committee on Planning and Development; and 105 from regular sources. (A tally at the end of this summary shows the disposition of each item.)

### Abortion

After long debate before the reference committee and on the floor of the House, delegates adopted the following statement on abortion:

"Whereas, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, The standards of sound clinical judgment, which, together with informed patient consent should be determinative according to the merits of each individual case; therefore be it

"Resolved, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his State; and be it further

"Resolved, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

### Consumer Forum

For the first time in its history, the House appointed a special reference committee to hold a public forum, at which individuals and representatives of groups could present their views of medical and health care. The committee heard three hours of testimony on the opening day of the convention. From its report, the House adopted the following recommendations:

"That consideration be given by the Board of Trustees to the creation of a multi-ethnic advisory committee on health care problems of minority groups.

"That the House of Delegates reaffirm its policy of encouraging physicians, as well as paramedical personnel, to continue to provide compassionate and sympathetic care to all patients.

"That the House of Delegates reaffirm Resolution 62, Annual Convention 1969, which states in part: 'It is a basic right of every citizen to have available to him

adequate health care' . . . and that 'the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.'

"That the AMA Advisory Committee on Health Care of the American People be invited to participate in reference committee hearings" of this type if they are held in the future. Consideration of having such an open forum at each AMA convention was referred to the Board of Trustees.

### Dues Increase

Until this convention, the amount of AMA dues was prescribed by the Board, for adoption or rejection by the House. On Tuesday, however, the House amended the bylaws to give itself that responsibility. Chapter III, Section 1 (A) of the bylaws now reads:

"(A) How Prescribed—Annual dues for any year shall be prescribed in an amount fixed and determined by the House of Delegates.

The Board of Trustees may submit recommendations to the House on the fiscal needs of the Association and the level of dues. Dues fixed by the House shall remain in effect until changed."

In response to Board Reports A and B (financial statement of the AMA, and background detail on the need for an increase), the House voted to increase annual AMA dues by \$40, to \$110. At the same time, the House directed that "basic and explicit information supporting the need for this dues increase, and future dues increases, be promptly disseminated by the AMA to individual members by every reasonable and available means possible; and that the aid of constituent state associations be enlisted in this effort."

The new dues will become effective with the next fiscal year, beginning December 1, 1970.

### Planning and Development

One of the longest debates of the meeting involved creating a body for long-range planning and development. When the matter was settled, a standing committee of the House—the Council on Long-Range Planning and Development—had been created and the bylaws had been changed appropriately to accommodate it.

The council will have nine members. Four will be appointed by the Speaker (two from the House and two from AMA membership at large) and four will be appointed by the Board (two members of the Board and two from AMA membership at large). The ninth member will be appointed by the President of SAMA. The council is required to submit reports to the House at each regularly scheduled convention of the AMA.

The House also acted on the recommendations of the earlier Committee on Planning and Development (Himmler committee). Here are those recommendations as adopted by the House, sometimes after extensive revision:

### RECOMMENDATIONS

That the AMA reaffirm, as a statement of the primary purpose and responsibility of the association and the medical profession, "the promotion of the art and science of medicine and the betterment of public health," and, as part of this purpose, apply all possible effort to make



medical services of high quality available to all individuals.

That the association has the duty to guide and assist the medical profession in the attainment of this objective.

That the American Medical Association recognize the need for multiple methods of delivering medical services, and that it encourage and participate in efforts to develop them.

That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence and freedom of choice for both physicians and patients.

Health is a state of physical and mental well-being.

That the AMA expand its active role in planning and developing programs for medical care in all of its ramifications and that it encourage and assist state and county medical societies to do the same at their respective levels.

That, clearly recognizing the health of individuals has many aspects other than medical care, such as education, housing, environmental control, transportation, civil rights, and the alleviation of poverty, the American Medical Association continue to show an active, innovative and constructive interest in these non-medical components of health services.

That the AMA and the constituent and component medical societies seek the active cooperation of all physicians, both as individuals and as members of medical staffs, in medical service projects for areas in need of medical services.

That the AMA, through its Council on Health Manpower, in conjunction with county and state medical societies and other professional, education, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

That the association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are not due merely to an insufficient number of health professionals across-the-board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

That the association publicize the reasons for the maldistribution, as outlined in this section, and stress that the voluntary correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

That an appropriate committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their services, and supervision of their services by qualified physicians.

That the AMA reaffirm the principle that the basic responsibility for the medical care of patients lies with their physicians of record and that that responsibility cannot be legally or morally delegated.

That the AMA approve in principle certification of educational programs for physicians' assistants but oppose licensing of these individuals by any state agency.

That the association's law division upon request assist

the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of physicians' assistants.

In seeking as its goal the highest quality and availability of patient care, the American Medical Association advocates factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments.

That the association, in appropriate public statements, emphasize the concept that differences in education, state laws, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups and different geographic areas.

Urge state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice.

Through the AMA's Departments of Survey Research and Economic Research, continue to assist state associations in collecting such data and to act as a clearinghouse for data so gathered.

Encourage state medical associations to designate representatives to deal energetically with third-party agencies and programs, utilizing the concept of usual, customary or reasonable charges.

That the AMA reiterate its support of sound, existing mechanisms, such as public grievance and adjudication committees, and utilization and peer review committees, which state and county medical societies have found to be most appropriate and effective for the consideration of fees and the costs of medical and related care.

Endorse the principle of voluntary, life-long postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

That the AMA encourage and assist all state medical associations to devise programs for voluntary postgraduate study designed to maintain medical education at the optimum level with the primary objective of assisting the physician in rendering professional services to his patients. These programs of postgraduate study should be mindful of the many demands on the time of the busy physician, and his responsibilities to his patients and his practice, and should be least disruptive to the provision of medical services.

That the association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for medical practice and restoring the licensing authority to the proper agency.



The AMA, on the basis of the data received from the state medical societies, (1) continue to identify the services that comprise good medical care; (2) develop guidelines that state and county medical societies may use in evaluating needs and priorities of medical services in their respective areas, and (3) ensure that these data and guidelines are widely distributed and publicized.

That the present structure of the Association be retained and that it be strengthened by improvements and modifications in its function.

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

### Education

In December 1968, the House agreed that "an ultimate goal is unification of the internship and residency years into a coordinated whole." To move closer to that goal, in this meeting the House adopted the following statements:

"After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The House also adopted or approved essentials of approved programs in continuing medical education; essentials of an accredited educational program for histologic technicians; revision of essentials of approved internships and residencies pertaining to part-time appointments; essentials for approval of examining boards in medical specialties; revision of essentials of approved residencies in child psychiatry; revision of essentials of approved internships and residencies to add statement on employment relationships of house officers; revision of essentials of approved residencies in neurological surgery; revision of essentials of approved residencies in pathology; and revision of essentials of approved residencies in internal medicine.

A permanent Section on Neurological Surgery was created in the Scientific Assembly of the AMA.

### Professional Liability

The House approved a Board report stating that liability insurance protection is essential so that physicians may continue to provide needed medical care to the public. "It has been concluded," the report said, "that the best way to provide such assurance is on a collective, rather than an individual basis, under programs jointly sponsored by the American Medical Association and the respective state medical association . . . Minimum standards for an effective sponsored insurance program are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means for instituting qualified insurance programs under such joint sponsorship with state associations which elect to participate."

### Nurses and Other Allies

The following AMA position statement on nursing was adopted:

"The American Medical Association recognizes the need for, and will support efforts to increase, the number of nurses; recognizes the need for, and will facilitate the expansion of, the role of the nurse in providing patient care; encourages and supports all levels of nurse education; will promote and influence the development of a hospital nursing service, similar to a medical care service, under the leadership of a chief of professional service, aimed at increased involvement in direct medical care of the patient; supports the concept of the physician-led health team; and will seek constructive collaboration with the total nursing community."

The House also resolved that "the American Medical Association undertake a thorough investigation of a method to bring allied professions into a collaborative relationship with the AMA such as the establishment of a new class of membership," and "that consideration be given to preparing 'essentials' for those categories of the allied health personnel groups which do not have them, and that the opportunity for vertical and horizontal mobility be considered in determining these 'essentials.'"

### Convention Sites and Dates

The 122nd Annual Convention of the AMA, originally scheduled for July 1973 in New York, has been changed to June 24-28. It will be in New York.

The Clinical Convention of 1972, originally planned for Atlanta, will be held in Cincinnati, Ohio. The 1976 Clinical will meet in Philadelphia.

This is the line-up now:

	<i>Annual</i>	<i>Clinical</i>
1970	Chicago	Boston
1971	Atlantic City	New Orleans
1972	San Francisco	Cincinnati
1973	New York	Anaheim
1974	Chicago	Portland, Ore.
1976		Philadelphia

### Drugs

The House took a number of important actions in connection with drugs. Among them:

That the AMA "encourage Committees on Pharmacies and Therapeutics in each hospital to review drug reactions and related problems and to take appropriate control measures and to initiate informational programs."

That the AMA "seek passage of legislation for control of the manufacture and distribution of barbiturates and amphetamines."

That the AMA "expresses the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies."

That the AMA "supports dispensing by pharmacists of all medications in child-protective containers, and encourages acceptance of the containers by parents."

And that it is contrary to the public interest to repeal



or modify "antisubstitution laws and regulations in order to permit the filling of prescriptions with therapeutic agents not intended by the prescribing physician." The House declared its intention "vigorously to support the maintenance and enforcement of anti-substitution laws and regulations."

### Hospitals

The House resolved that "the terms 'negative,' 'within normal limits,' and 'normal' be approved by the JCAH as acceptable designations for use in hospital charts."

It also resolved:

That the AMA request the JCAH to specify that a Joint Conference Committee "include, where feasible, adequate representation from community-based physicians elected by the medical staff."

That the AMA reaffirm its position that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities."

And that the AMA suggest that "medical staffs consider revising their respective hospital medical constitutions and bylaws to differentiate clearly between medical and administrative duties."

### Miscellaneous

The House supported the Board's plan to establish a wholly owned, separate subsidiary corporation to engage in publication and possibly other related activities now carried on by the AMA in order to gain various economies, lower costs and better administrative and accounting procedures.

Delegates adopted a Board proposal to undertake a "Communications Program for the 1970's," consisting of television documentaries, educational advertising, media relations and other related activities "to improve public understanding and opinion of the profession."

Approval was given to Report A of the Judicial Council, which said, among other things, that "It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical."

The bylaws were amended to permit osteopaths in military service to become service members of the AMA.

The House resolved to "support continuing efforts by the American Medical Association to inform the medical profession of the value and benefit to be realized from the implementation of adequate peer review programs" and directed the Board, the Council on Medical Service and "other appropriate sections of the AMA" to give this project "the highest priority and emphasize its urgency to all state and component medical societies."

Mindful of its obligation to protect public health, the House called on each state society "to take whatever steps are necessary to inform state legislators about the health hazards posed by the cult of chiropractic." It also encouraged medical schools "to include specific information in their curricula regarding the nature of the health hazard to individuals . . . posed by quackery

in general and the unscientific cult of chiropractic in particular."

The House directed the AMA to make a detailed and comprehensive study and analysis of the methods and requirements for reporting infant mortality statistics "by those nations that are alleged to have a lower rate of infant mortality than that of the United States."

Delegates resolved that the AMA continue its efforts "to alert the American people . . . to the ever increasing health hazards of environmental pollution and to the urgent need for expanded research and effective control measures;" and that the AMA "further extend and intensify its present activities in pollution control and improvement of environmental health."

Considering the plight of prisoners of war in North Vietnam, the House recommended that, "in the best medical interests of both servicemen and their families, the World Medical Association and/or other appropriate international organizations be requested to use their influence with those countries which do not subscribe to the Geneva Convention to the effect that (a) a list of prisoners' names be furnished, (b) inspection of prisoner compounds by neutrals be carried out, and (c) medical supplies and food parcels, as well as mail, be distributed to prisoners."

### Awards

Charles B. Huggins, MD, of the Pritzker School of Medicine, Chicago, was presented the Dr. Rodman E. and Thomas G. Sheen Award at the opening session of the House, along with the check for \$10,000 which accompanies the award.

Special awards were presented to the stars, creator and producer of the ABC-TV program, "Marcus Welby, MD." Robert Young (who portrays Dr. Welby); James Brolin (who plays the assistant, Dr. Kiley); David Victor, creator and executive producer; and David O'Connell, producer all received plaques in front of the House. The program and the people responsible for it were cited for portraying "the human understanding and uncompromising care which physicians give to their patients."

Also honored at the opening session of the House were the AMA winners in the 21st International Science Fair held in Baltimore, whose exhibits were on display throughout the Scientific Assembly.

The winners were Beverly Fordham, a junior at Bryan Adams High school in Dallas: "Determination of Alpha Vigilance via Electroencephalography;" and Kevin Boran, senior at Lawton's Hill school in Pottsville, Pennsylvania: "Effects of Antidiuretic Hormone on Sweating Activity and Sweat Composition."

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### NOVEMBER 29-DECEMBER 2, 1970 BOSTON

The Faculty's three Delegates to the AMA House of Delegates, plus the Senior Alternate Delegate, attended all sessions of the House during the AMA's Clinical Session, held in Boston, Massachusetts, November 29-December 2, 1970. In addition other alternate delegates attended some of the sessions, as well as being available to staff Reference Committee hearings



on the various resolutions, reports and speeches presented to the House sessions.

At this meeting, recognition was paid to J. Sheldon Eastland, MD, who was serving his last term in the House of Delegates.

In addition, the resolution offered by the Maryland Delegation on instructions of the Council, was rejected because this information is currently in the process of development and will be available within the near future. The following is a summary of the actions taken. (Complete records of the proceedings may be found in the appropriate issue of *JAMA* or by contacting the Faculty office for further details found in this report.)

#### Presidential Address

The American Medical Association must "take a leadership role" in development of neighborhood medical clinics, which are fast becoming "the focal point for delivery of most medical services," Walter C. Bornemeier, MD, AMA president, told the House of Delegates.

"As the government takes on an increasing role in health care, as costs continue to rise, as local and state governments are confronted with increasing demands on limited public funds, as groups such as organized labor continue to push for nationalized health services, we can expect federal legislation to zero in on neighborhood medical clinics," Dr. Bornemeier said. AMA leadership is thus vital, "so that we may insure that medical clinics remain a part of private practice," he said.

Dr. Bornemeier's proposals include:

—Creation of a program to assist physicians in setting up adequate health facilities, for group or solo practice. A number of services would be covered, including architectural drawings, site requirements, management and operational plans, staffing requirements, equipment schedules and suggestions for obtaining financing from local banks.

"In essence," Dr. Bornemeier said, "I seek a means whereby young physicians can be well advised and local medical societies will be involved in organizing and maintaining control of medical clinics. I believe that if we just leave it up to each medical community to act in its own way, medicine will default to hospitals, to government and to social service agencies who even now vie for control of the mechanisms which deliver medical care. The young doctor going into practice must be able to see that AMA is here to help."

—As the concept of charity medicine fades while insurance plans grow, inducements to doctors to establish private practice groups in the ghettos should be considered, such as low cost federal loans or Hill-Burton type grants, Dr. Bornemeier said. "The poor must have access to medical care on the same basis as the most affluent citizens," he told delegates.

—The AMA should conduct a periodic survey of manpower needs in each specialty across the country. Results of the survey would go to each senior medical student showing how many general surgeons, internists, etc., are now available and how many are needed. This would help the student in choosing a specialty in de-

mand, and help balance those specialties in short supply, the AMA president said.

Dr. Bornemeier repeated suggestions he made upon inauguration last June as the AMA's 125th president, that medical education be shortened to six years, that the method of training specialists be reviewed to emphasize ambulatory patient care rather than in-hospital care, and that new MD's train at the side of experienced physicians in preceptorship programs.

He added, "This House should be concerned with plans to bring a substantial portion of the graduate training programs back under the control of the practicing physician, instead of the present tendency to shift supervision to employees of the hospital administration."

Dr. Bornemeier complimented the House for having "acted responsibly" in the past, on updating policies. He cited the entry into the field of student loans, approval of a study of neighborhood health centers, and requesting of federal grants for the study, along with approval of sponsorship of professional liability programs jointly with state associations.

The president's new proposals were received with enthusiasm by many delegates and studied by reference committees. Later, suggestions concerning medical education were referred to the Council on Medical Education to "aid it in its deliberations" on the problems discussed, while other proposals were referred to the Board of Trustees "for careful consideration by the appropriate AMA councils, committees and staff."

#### HOUSE ACTIONS

From November 29 through December 2, the House was in session 10 hours and 50 minutes, during which time it considered 32 reports and 71 resolutions, plus four memorial and commendation resolutions. A complete tally at the end of this summary shows disposition of each item.

##### Abortion

Although it appeared that a renewed and lengthy debate on abortion would ensue, delegates deemed otherwise: They rejected attempts to change the policy statement adopted at the 1970 annual convention and, after brief discussion, reaffirmed that policy.

##### Membership

The House created a new class of membership for interns and residents. The action, recommended by the Board of Trustees, will allow such members to elect a delegate and alternate to the House. Dues will be \$20 annually and the new members must convert to active or service membership upon completion of their training programs. The House also approved revision of the Bylaws to provide for a direct membership category, with payment of AMA membership dues by physicians in the Veterans Administration, nonuniformed physicians of the Public Health Service and other fulltime civilian physicians employed by federal agencies, who are ineligible for membership in a component medical society. Uniformed Public Health Service physicians remain service members.

##### Peer Review

The House reaffirmed its approval of Peer Review Organization, as contained in the AMA Medcredit



program, and urged that "all components of organized medicine give energetic support to furthering the effective implementation of peer review." Action came almost simultaneously with Senate Finance Committee modification of several provisions in the Social Security Bill regarding professional standards review organizations (PSRO). The AMA had objected to the provisions, among which were: pre-admission approval requirements; national norms of care; federal ownership of PSRO files; a \$5,000 fine for violations, and review of all services provided.

The Senate committee announced that it had: deleted the requirement of federal ownership of files; deleted the \$5,000 fine but retained provisions for refunds of fees; eliminated national norms but retained provisions for regional norms, and eliminated the necessity of pre-admission approval for all elective procedures, but allowing the PSRO to specify those situations where preadmission would be required.

The committee report also was to specify that the PSRO could not be a medical society, but could be organized and set up by a medical society, such as a foundation. The bill now provides that no PSRO shall utilize a nonphysician to make final determinations regarding professional conduct of any physician, or any act performed by a physician in the exercise of his profession. The House directed the Board of Trustees to continue to seek appropriate changes in the bill.

#### Professional Ideals

"The age old professional ideal of medical service to all, whether able to pay or not," affirmed by the House in 1934, was emphatically reaffirmed by delegates in Boston. They acted on a recommendation by the Judicial Council, which said it had received "many letters complaining of an apparent preoccupation by an increasing number of physicians with the financial aspects of their medical practice."

Ideally, the physician should be paid promptly, the Council said. But it added that if he is not paid as promptly as other creditors, "he should recall that he is a professional man with all the prerequisites that term implies." It criticized such "real examples" as adding 1½ per cent interest per month to the bill of a patient on a small pension, and refusal to see a patient because the patient's balance was too high. "The council believes these examples are the exception . . . Nonetheless (they), reflect adversely on the whole profession and especially on the countless physicians who extend credit willingly or write off old accounts because they are dedicated to serving mankind." The House not only adopted the report, it urged wide dissemination of it to component and constituent medical societies.

#### Health Occupations

The terms "ancillary" and "paramedical" will no longer be used in AMA statements, but will be replaced by the term "allied", the House decreed. It also approved a Board of Trustees report dealing with licensure of health occupations. Recommendations in that report include: State legislatures be urged to amend state medical practice acts to remove any barriers to increased delegation of tasks to allied personnel by

physicians; that alternative routes to licensure, such as job performance tests, be studied; that programs for periodically updating knowledge and skills of currently licensed or certified occupations be encouraged; and that the House of Delegates call for a nationwide moratorium on licensure of any additional health occupations. Delegates are asking the American Hospital Association and American Public Health Association to join in supporting the moratorium. Consideration of a national "task force" to study the problem of licensure in detail was approved. Such a force would represent health professions, educators and governmental agencies.

#### Elections

The House defeated measures seeking to change the manner of electing members of the Board of Trustees. The measures would have had trustees elected at large and on a regional basis.

#### Convention Sites

Atlantic City was approved as the site of the 1975 annual convention, but only tentatively. The California delegation said final approval should be determined "on the basis of our experience in 1971," at the annual meeting in the New Jersey resort. The House agreed. In another move, delegates approved Honolulu as site of the 1975 clinical convention. Dallas will be the site of the 1976 annual convention.

#### Miscellaneous

Osteopathic physicians are now eligible for the AMA Physician's Recognition Award, if they meet all regular requirements. In approving this step, the House noted that it is in line with previous actions which made osteopathic graduates eligible for approved internships and residencies. Delegates also voted to coordinate educational requirements for the Award with those for continuing membership in the American Academy of Family Practice.

The House urged expansion of third-party coverage for out-of-hospital care. It directs the AMA to seek immediate adjustment of all such programs to provide equal coverage for physicians services, where rendered, and removal of restrictions which would require hospital care, where ambulatory services would be effective, in order for benefits to be paid. In another action, delegates urged that the insurance industry write their contracts to cover the newborn from the moment of birth, instead of after a waiting period as now observed. The latter was inserted in a resolution dealing with the upcoming White House Conference on Children.

Delegates gave "strong support" to the SAMA-MECO Project as an adjunct to undergraduate medical education, and asked constituent medical societies to consider supporting the project in their states. The full name is the Student American Medical Association Project for Medical Education and Community Orientation. More than 250 students have taken part in the project in over 100 community hospitals, with 500 practicing physicians.

The House approved a Board of Trustees report calling on constituent associations to seek appropriate remedial state legislation in the field of professional liability, and encouraged the Committee on Professional



Liability to continue to explore all aspects of the professional liability problems.

Delegates approved expansion of the Advisory Committee on Health Care of the American People to encompass multiethnic representation. The move grew out of a recommendation made after last June's annual convention, where a special reference committee held a public forum to hear the views of various groups on medical and health care.

The House also heard a report dealing with a recent decision of the Illinois Supreme Court in connection with blood transfusions. In essence, it holds not only physicians and hospitals liable for conditions caused by such transfusions, but also the donor and the agency concerned with collection of the blood.

The AMA House went on record as urging states to see that legislation is enacted to afford protection of all those concerned, except for gross negligence.

Respectfully submitted,

ROBERT V.L. CAMPBELL, MD

J. SHELDON EASTLAND, MD

RUSSELL S. FISHER, MD

CHARLES F. O'DONNELL, MD, *Senior Alternate Delegates*

## COMMITTEE ON EMOTIONAL HEALTH

*Mr. President and Members of the House of Delegates:*

The Committee on Emotional Health held a number of meetings throughout the past year under the chairmanship of Exall L. Kimbro, Jr., MD. Many current issues were studied and recommendations made, and special emphasis was placed on the treatment of the hospitalized mentally ill patient, and provision of health services to the drug abuser.

The year started with a resolution to invite residents from the accredited psychiatric training institutions in Maryland to attend meetings of the Emotional Health Committee as nonvoting members (if the resident is a member of Med-Chi, he is a voting member) with specific recommendation that two residents be selected by their fellows with the invited institutions to be changed on an annual rotating basis.

The committee moved that the Faculty endorse the concept that hospitals with 100 beds or more include beds for the care of psychiatric patients. This was adopted by the Council. Discussions were held with Dr. Matthew Tayback and Dr. Eugene Guthrie of the Maryland Comprehensive Health Planning Agency, who informed all the regional mental health directors of the resolution and of the willingness of the Committee on Emotional Health to consult with general hospitals wishing to plan a psychiatric unit.

A symposium entitled "Psychiatric Unit in the General Hospitals" was held at Prince George's General Hospital on December 4, 1970. Administrators, directors of nursing, directors of medical services, and psychiatrists from hospitals of 100 beds or more were invited to attend. The object of the symposium was to encourage general hospitals to establish psychiatric units. Twenty-two hospitals and two county health departments were represented. The meeting was well received and the speakers were excellent.

A resolution was submitted to the Faculty regarding increasing enrollment in medical schools. The resolution was approved by the Council of the Faculty and referred to the Public Relations Committee for implementation.

Subcommittees have given extensive thought and discussion to four areas:

1) Transportation of the Hospitalized Mentally Ill. Considerable work has been done in studying the transportation of the mentally ill from community to state hospitals. It was moved that the committee inform the county health officers of the possibility of asking for a state grant through the Community Mental Health appropriation to finance transportation of mentally ill patients by trained attendants, experienced in the transportation of such patients;

2) Mental Health Services in Adult Correctional Institutions. Continuous work is being done in this area and any action necessary will be taken in the future.

3) Mental Health Services for Children and Adolescents. A collection of information on "hotlines" in the various counties is being made with this information to be compiled for distribution to the different counties. Two members of the committee met with the acting director of the Department of Juvenile Services. Also, a letter was sent to various facilities in the state regarding the handling of disturbed children and adolescents to study just what is available in this area.

4) Mental Health Services to the Drug Abuser. Guidelines were adopted for treatment of the drug abuser. It was recommended by the committee that the private practitioner be encouraged to cooperate in the treatment of the drug addict. A letter was sent to Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, stating that the committee felt there is an urgent need to provide drug treatment facilities in every major population center in the state.

5) Mental Health Services to the Elderly. A study is being conducted in this area.

Respectfully submitted,

EXALL L. KIMBRO, JR., MD, *Chairman*

EDUARD ASCHER, MD

AUGUSTO J. ESQUIBEL, MD

THEODORE M. FELDBERG, MD

JAMES J. GIBBS, MD

GERTRUDE M. GROSS, MD

ERNEST E. HARMON, MD

STEPHEN A. HIRSCH, MD

DAVID W. LOCKWOOD, MD

ADDISON W. POPE, MD

ALBERT M. POWELL, JR., MD

CHESTER W. SCHMIDT, JR., MD

DAVID W. SHAVE, MD

LOUIS W. TINNIN, MD

H. THOMAS UNGER, MD

WITOLD V. WINIARZ, MD

WILLIAM KENNER, MD, *Advisory member*

ARTHUR FREEMAN, MD, *Advisory member*

## FINANCE COMMITTEE

*Mr. President and Members of the House of Delegates:*

The investment portfolio of the Faculty's special dedicated funds was reviewed in detail with a counselor of the T. Rowe Price Company by the members of the Finance Committee.



The stock market decline which began near the end of 1968 and ended in May 1970 was the longest and most severe in 37 years. The Dow Jones Industrial Average was down 36% for that period. The Faculty portfolio was off 2.7% at December 1970 from December 1969, which is not nearly as severe a decline as suffered by other investors.

A summary of the portfolio at December 31, 1970 shows the market value of invested capital at \$1,064,126.43. The approximate income or earnings of the fund was \$34,168.40. The yield on invested capital was 3.8%. The investment accomplishment in 1970 of the Faculty portfolio is favorable when compared to other similar endowment funds.

The market is now recovering. Although the magnitude and degree of acceleration of economic growth during the current year remains controversial, the trend is clearly favorable.

The Finance Committee determined that the annual earnings of the Laughlin Fund have reached the point where it is now possible to grant awards. The Executive Committee will be requested to establish criteria or guidelines for expending the income for awards.

Respectfully submitted,

KARL F. MECH, MD, *Chairman*  
M. MCKENDREE BOYER, MD  
A. C. DICK, MD  
E. W. DITTO, JR., MD  
THEODORE G. OSIUS, JR., MD

## HEARING AND VISION EARLY SCREENING

*Mr. President and Members of the House of Delegates:*

This is the first report of activity in connection with the newly-formed HAVES program. HAVES is a synonym for Hearing and Vision Early Screening and has recently been incorporated as a separate entity. The Faculty names a majority of its Board of Trustees and the corporation is responsible to the Faculty's Executive Committee. Other members of the Board are designated by the Maryland Society for the Prevention of Blindness, which is cooperating with the Faculty in developing this new program.

Seed money has been made available to HAVES from the Faculty's Community Health Projects Fund. It is anticipated this may be replaced at a later date, thus enabling the Faculty to reuse the seed money for other worthwhile projects.

HAVES is devoted to the detection of hearing losses as well as vision deficiencies in preschool children. It is patterned after other, similar programs that have received nationwide publicity in recent years.

Many of the Faculty members may not be fully aware of the fact that a vision screening program has been operating throughout the state for many years under the auspices of the Maryland Society for the Prevention of Blindness. This hearing survey will serve as an adjunct to the basic program of detection of vision deficiencies.

Progress has not been as fast as would have been possible had an acceptable machine been available to

be used by volunteers for the hearing screening. After pilot studies and tests were completed, arrangements have now been made for a "Proposed Study for the Feasibility and Reliability in Using the VASC Test in (hearing) Screening of Three and Four Year Old Children". This study has been submitted to the Board of HAVES, Inc. by a local PhD specializing in speech and hearing defects. It will be financed by the Zenith Corporation, manufacturers of the VASC machine.

Volunteers are currently being recruited for this new adjunct of hearing testing, and it is anticipated that the screening program will commence in the fall of 1971. This initial study will be a pilot project on about 500 children conducted under the supervision of the project director mentioned above.

This entire proposal has the enthusiastic endorsement of the Maryland ENT Society, the Maryland Ophthalmological Society, and the Maryland Chapter of the American Academy of Pediatrics.

Prior to the Board becoming official, the Faculty's Child Welfare Subcommittee spearheaded the activity in this area. The special committee was discharged when the HAVES Board came into existence.

Respectfully submitted,

KARL M. GREEN, MD, *President, Board of Trustees*  
CYRUS L. BLANCHARD, MD  
MRS. JANE DAVIS ELLEN  
RICHARD E. HOOVER, MD  
ARNALL PATZ, MD  
MARGARET L. SHERRARD, MD  
ALVIN P. WENGER, MD

## LEGISLATIVE COMMITTEE

*Mr. President and Members of the House of Delegates:*

This committee has held several meetings during the year, but the bulk of the activity has been performed on a routine basis by the committee chairman, individual members of the committee, and staff. Complete details of the 1971 General Assembly session can be found in the regular issues of *The Assemblyman*.

Because of the press of legislative activity, it was only possible to publish two issues of this publication. The first was just prior to the session convening; the second after adjournment.

Several of the component societies are now meeting on a regular basis with their legislative delegations. At this time, they are discussing current issues offering assistance on medical and medically-related matters.

This has been an active year for the Legislative Committee and one that shows no signs of abating. It is anticipated that during the coming Faculty year, much attention will be paid to Legislative Council activities, as well as the legislative program for 1972.

Respectfully submitted,

B. MARTIN MIDDLETON, MD, *Chairman*  
MARSHALL DIAMOND, MD  
JOHN FENWICK, MD  
WATSON P. KIME, MD  
STEPHEN K. PADUSSIS, MD  
J. MORRIS REESE, MD  
ROLAND T. SMOOT, MD  
C. C. SPENCER, MD  
WILLIAM A. WILLIAMS, MD; MRS. PEDRO S. DEBORJA  
ELIHU E. ALLINSON, MD JOSEPH P. CAPPUCCIO, DDS



## LIAISON COMMITTEE

*Mr. President and Members of the House of Delegates:*

Two meetings of the Liaison Committee were held, at which time in-progress reports were received from the various subcommittees under the general liaison aegis.

Among the general questions considered were utilization of hospital emergency rooms, school bus drivers' examination forms, and medical scholarship information.

In connection with the use of hospital emergency rooms, it was pointed out by the chairman, James B. Brooks, MD, that a communication had been sent to all component societies indicating that the practice of indiscriminately "dumping" patients on hospital emergency rooms is strongly condemned by the Faculty. A discussion of transporting injured patients centered around the use of helicopters. Finally, it was agreed that all items of emergency care be referred to the Subcommittee on Medical Emergency Service of the Postgraduate Education, Preventive Medicine and Public Health Committee.

In considering a state House resolution requesting that the Faculty study ways of rendering better health services to the community, especially in the area of house calls, it was agreed that while the problem has been blown out of proportion, the public should be educated to understand that it should establish a relationship with a family physician before emergency care is needed.

On the question of the medical scholarships available to ten Maryland students, William Stewart, MD, outlined the background of the program. He said that the application form had previously contained only an inconspicuous notation indicating that applicants would be expected to serve three years in Maryland as a general practitioner in return for the scholarship. While only one of the first ten students graduating on this scholarship had indicated his intention to remain in general practice in Maryland, it is hoped that a new screening procedure being instituted to include a revised application form and personal interviews will result in more productive future classes.

### Nursing Liaison Subcommittee

A series of meetings was held by this subcommittee which helped clarify areas of question of protocol and continue maintenance of favorable relationships between the two professions. It was reported at one meeting that Maryland is far ahead of other states in cooperation between the nursing and medical professions, working together for the common good.

A statement of policy of the Maryland Nurses Association and the Medical and Chirurgical Faculty was issued concerning the proposed addition to Nurses Protocol Regulating the Practice of Nurse-Midwifery in Maryland. It was emphasized, however, that no statement of policy by any professional organization or by an employing agency can relieve the individual nurses of responsibility for his or her acts. A statement of policy will not provide immunity from legal action if the nurse is negligent. Part of the statement clarified that the certified nurse-midwife always functions

within the framework of a medically directed health service; she is never an independent practitioner nor may she accept fees from patients for her services.

In a discussion concerning the growing feeling that there should be recognition and licensure of paramedical personnel in the role of the physician's assistant, it was agreed by all members that such licensure should be by the Board of Medical Examiners for the sake of coordination and control. The Maryland Nurses Association will be informed of this consensus by the subcommittee.

There was considerable discussion and resolution of responsibility in several areas such as that of the nurse who trains fire department ambulance personnel to give IV therapy, supervision of aides to carry out tuberculin testing programs, administration of medications prepared by pharmacy technicians in hospitals, and the status of physician assistants.

Respectfully submitted,  
JOHN F. SCHAEFER, MD, *Chairman*  
W. KENNETH MANSFIELD, MD  
MELVIN N. BORDEN, MD  
MRS. IRENE F. ODDO, RN  
MRS. FRANCES TOMPKINS, RN  
MRS. ELEANOR REESE, RN

### Nursing Home Liaison Subcommittee

Because of tremendous public interest and concern with nursing homes, this subcommittee had an exceptionally busy year. It was specifically concerned with defining the qualifications and responsibilities of a medical director in chronic disease facilities, and forming a resolution requesting the development of a medical standards committee. This committee would perform the society's role as leaders in recognizing and meeting the needs of all patients by determining ways that a medical director in a particular institution may fulfill these unmet needs.

These statements were formed after a series of lengthy meetings of this subcommittee in conjunction with Maryland Association of Homes for the Aging, and the Health Facilities Association of Maryland.

Most of the discussion dealt with developing procedures for insuring physician responsibility in fulfilling obligations for regular patient care, and in defining the differences between physician and administrator responsibilities.

A resolution was finally adopted proposing that "... the Faculty insist on, develop, and promote a Medical Standards Committee fashioned after regional, component society, or district peer review and utilization review mechanisms, to perform the society's role as leaders in recognizing and meeting the needs of all patients by determining the manner in which a medical director in a particular institution may fulfill these unmet needs ..."

Respectfully submitted,  
J. RAYMOND GLADUE, MD, *Chairman*  
RAYMOND BENACK, MD  
LOUIS V. BLUM, MD  
ARTHUR E. COCCO, MD  
CARIDAD E. GONZALEZ, MD  
HAROLD HARBOLD, MD  
AUBREY RICHARDSON, MD  
WILLIAM J. MAREK, MD



GEORGE SHARPE, MD  
CHARLES C. SPENCER, MD  
EMERSON C. WALDEN, MD  
JOHN D. YUN, MD

#### Pharmacy Liaison Subcommittee

This subcommittee heard reports from pharmacists that some physicians had been directing patients to chain pharmacies, indicating that prescription charges would be lower. This is considered unethical practice by a physician, and a letter so indicating was directed to the Faculty. It was also pointed out that the group felt it is just as important to have a family pharmacy as to have a family physician so that a permanent record of prescriptions could be maintained.

On the question of revealing information concerning particular prescriptions to another physician, it was voted that in this committee's opinion, it is advisable that pharmacists give information on medication when requested by another physician. It was also agreed that the pharmacist should not discuss prescriptions with patients unless so authorized by the physician. In the filing of insurance forms, however, the pharmacist has no choice and must indicate the medication prescribed.

Other matters related to physician-pharmacist relations were discussed. Included among these was the question of illegible physician signatures on hospital prescription blanks. A Senate bill in the legislature would require the physician to print his name on any blank which lacks the name of the prescriber.

Respectfully submitted,  
MELVIN N. BORDEN, MD, *Chairman*  
MR. NATHAN I. GRUZ  
RICHARD K. GUNDRY, MD  
NATHAN NEEDLE, MD  
STANLEY FELSEBERG, MD

Respectfully submitted,  
JAMES B. BROOKS, MD, *Chairman*  
MELVIN N. BORDEN, MD  
ROBERT E. FARBER, MD  
J. RAYMOND GLADUE, MD  
GEORGE H. GREENSTEIN, MD  
PAUL F. GUERIN, MD  
JOHN H. HIRSCHFELD, MD  
EDWARD O. HUNT, JR., MD  
DONALD W. MINTZER, MD  
JOHN F. SCHAEFER, MD  
WILLIAM L. STEWART, MD  
H. LEONARD WARRES, MD  
JEAN ROSE STIFLER, MD

#### LIBRARY AND HISTORY COMMITTEE FINNEY FUND COMMITTEE

*Mr. President and Members of the House of Delegates:*

During 1970, the library continued the weeding, sorting, and final auctioning program begun earlier. To date (May 1971) there have been four auctions through Swann Galleries, Inc., of New York city which have netted the Faculty a total of \$7,583. There will be several more smaller sales later on which should bring this total to approximately \$8,500 or more. Titles sold were duplicate copies or out-of-scope items.

Last year, the staff consisted of two full-time professional librarians, the Librarian and Assistant Librarian

in Charge of Technical Processing, one part-time professional general assistant, two part-time clerical assistants, and four student assistants, one of whom is now a full-time professional trainee.

Within the year, a number of major shifting projects were accomplished by removing books through withdrawal and sales. At present, most of the history of medicine collection is housed on the fourth stack, which can be locked. Five years of bound journals have been moved to the second stack to make space for incoming bound volumes.

Collection of monographs and pamphlets previously bound together are being disbound so that duplicates can be assembled and decisions made regarding their retention and possible sale. Some of these are valuable publications which are almost inaccessible when not analyzed by subject.

During the year, the librarian attended the meeting of the Medical Library Association in New Orleans and the Special Libraries Association annual meeting in Detroit in June.

In October, this library co-hosted the Washington, D.C. Area MLA Conference—the regional meeting of the Medical Library Association—with the Health Sciences Library of the University of Maryland. At this one-day conference, the North Carolina group of MLA members was welcomed into the area. Our staff assisted with programming, hosting, and moderating the sessions. This library also donated the honorarium paid to Dr. Norman S. Stearns of Boston, for his presentation of the core medical library plan for small hospitals.

One more section of shelves was added in the reading room and, in order to supplement the shelving in the stacks, wooden shelves were placed on the floor levels of the second and third stack shelves. This furnished quite an increase in footage which is badly needed for shelving bound journals. Plans now include four low sections of shelving to be placed in front of the two French windows in the reading room, which are never opened. This is a last resort, since space is so limited in the present building. Much shifting has been necessary in order to accommodate the journal collection as well as new accessions acquired during the past few years.

Estimates of space needed for the library in a new building have been approximated very tentatively in hopes that before many more years the Faculty will be able to have an adequate site and building to include all its activities. The librarian attended a one-day seminar on library planning and building held at the Biltmore Hotel in New York city, April 23, 1971, called "Blueprint for the 70's", sponsored by Special Libraries Association's New York Chapter. This meeting brought together architects, librarians, consultants, and managers to discuss all phases of planning and constructing libraries.

In September, Mrs. Sanford, Librarian, visited all the hospitals in Western Maryland to become acquainted with the library facilities in their organizations and apprise them of the availability of the services of Med-Chi's library. The contacts made on these trips proved helpful and promoted a better understanding of the problems of the library personnel in the hospitals. Following these visits, Mrs. Sanford met with members of



the Maryland Regional Medical Program to discuss possibilities for initiating a library program within their organization. We participated in the production of a continuing education film on use of the medical library, which was being made by the Audiovisual Unit, Johns Hopkins University, under Dr. J. D. Allred's supervision. It is expected that some further developments will be consummated during 1971-1972.

#### LIBRARY STATISTICS—1970

Circulation	
Journals	6,212
Books	3,470
Pamphlets and V.F.	400
<b>TOTAL</b>	<b>10,082</b>
Interlibrary loans charged out	3,362
Interlibrary loans borrowed	421
Pages Xeroxed	14,424
Acquisitions	
Books added	868
Bound journals added	434
<b>TOTAL</b>	<b>1,302</b>
Books withdrawn	1,860
Bibliographies	205
Gifts (Books and journals)	788
MEDIC Tapes and slides charged	72
Telephone calls	3,352
Attendance	2,523
Previous total volumes	94,118
Total volumes in collection	95,420

Respectfully submitted,

*Library and History Committee*

PAUL F. GUERIN, MD, *Chairman*  
 HAROLD H. GIST, MD  
 H. BERTON McCAULEY, DDS  
 KATHERINE A. CHAPMAN, MD  
 ROBERT B. GOLDSTEIN, MD  
 GEORGE A. MAXWELL, MD

*Finney Fund Committee*

D. C. W. FINNEY, MD, *Chairman*  
 THOMAS G. EDISON, MD  
 RICHARD G. COBLENTZ, MD  
 RICHARD W. TELINDE, MD  
 RICHARD V. HAUVER, MD

#### MARYLAND BLUE SHIELD, INC. BOARD OF DIRECTORS

*Mr. President and Members of the House of Delegates:*

In 1970, Maryland Blue Shield, Inc. completed another year of growth and progress. Plan enrollment again increased; subscription income was correspondingly larger; total payments made to physicians also continued to climb; programs were introduced to effect closer relationships with physicians; and certain administrative refinements were developed and implemented.

As of December 31, 1970, the plan had 1,238,346 subscribers, an increase of 6.83% over the 1,159,177 one year earlier. In the prior year, growth had been 5.6%. Although national statistics for the year's end are not yet available, data published for three quarters of 1970 show that on the average, plans with more than 1 million subscribers—the category which includes the Maryland Plan—increased their membership by 2.8%, while in Maryland, a growth of 5.43% was recorded in the same nine months. As of December 31, 1970, Maryland Blue Shield's membership was equivalent to 90% of Maryland Blue Cross enrollment. Of particular interest is the fact that more than 75% of our 1.2 million subscribers are enrolled for outpatient diagnostic benefits in addition to basic benefits. It is significant also that enrollment has continued to gravitate from Plan A into Plan B and Plan C. At year's end, Plan A enrollment represented only 6.6% of total enrollment, compared with 8.8% one year earlier; and Plan C enrollment represented 35% of the total, compared with 28% as of the end of 1969.

Total subscription income in 1970 increased to \$34.8 million, 18.4% greater than in 1969. Claims incurred totalled \$32.8 million, 24.7% greater than in 1969, and operating expense for the year amounted to 10.8% of subscription charges, exactly what it had been in 1969. As a result of the excess of benefit payments and operating expenses over subscription income, it was necessary to withdraw more than \$1.2 million from contingency reserves during the year.

Of the total of \$32.8 million in claims in 1970, inpatient surgical care accounted for about \$10.5 million; inpatient medical care, just over \$4 million; obstetrical services, nearly \$2.5 million; anesthesia, about \$2.1 million; and radiology and pathology, almost \$6 million. Claims for outpatient surgical services amounted to about \$5 million. These figures are suggestive of the importance of outpatient and diagnostic benefits, which at one time might have been considered by the public to be a minor element of total health care.

In 1970, payments made to physicians by the plan in its capacity as carrier for Part B of Medicare were almost identical to those made in 1969. A total of \$12,686,367 was paid in calendar year 1970; total payments in 1969 equalled \$12,273,508.

Representatives of the Professional Relations Department made a total of 3,547 visits to physicians' offices, resulting in 1,371 personal contacts with physicians and 2,559 personal contacts with physicians' office assistants. Additionally, in December, Maryland Blue Shield published the first issue of a new Physicians' Bulletin, designed to present in a more readily digestible form information of interest to physicians and their office staffs. The Medical Relations Committee and the Reference and Appeals Committee, both comprised entirely of practicing physicians, continued to guide the organization in policy matters and in the reconciliation of specific claim problems, respectively. As of the end of the year, the number of Maryland physicians participating with Blue Shield was 4,034, or nearly 90% of all physicians in private practice in the state.

In view of growing national and local attention to pre-



paid group practice as an alternate means of delivering medical care, the Board of Directors convened a special meeting in December, devoted exclusively to discussion of this subject. The agenda for the meeting featured an address by Mr. John Sargeant, Executive Director of the Medical and Chirurgical Faculty, as well as presentations by other special guests and Blue Shield staff members.

The first full year of operation of Maryland Blue Shield's formalized Utilization Review program was 1970. The program has generally been successful, not only in monetary savings to the plan and its subscribers but, of even greater importance, in helping to assure that medical facilities and services are properly utilized. The Utilization Review staff worked closely with the Faculty's Peer Review Committee in the resolution of the several significant problems that were identified.

Later in the year, a new dental program was introduced to complement in part the benefit plans now available for professional medical care. Maryland Blue Shield is among the first plans in the nation to offer such a program.

In the course of 1970, Blue Shield advertising emphasized the need for preventive medical care. In addition to use of the normal news and broadcast media, thousands of booklets addressed to drug abuse, alcoholism, and middle age were made available to the public. And the series of films on drug abuse was again shown on a local television station, hopefully adding to public recognition of this vicious problem.

The members of the Maryland Blue Shield Board of Directors wish to express their sincere gratitude for the cooperation and candid comments that have been offered by the members of the medical profession, and hope that such meaningful activity will continue in 1971 and in the years beyond.

Respectfully submitted,

J. SHELDON EASTLAND, MD, *Chairman*

## MARYLAND STATE MEDICAL JOURNAL

*Mr. President and Members of the House of Delegates:*

This past year marked several changes in JOURNAL staff personnel. Miss Judy Sowell, who managed the JOURNAL for three years, resigned in August, and Mrs. Debby Anderson, Assistant Editor under Miss Sowell, moved up to the position of Managing Editor. Mrs. Connie Walters joined the JOURNAL staff in July 1970, but also resigned early in January 1971.

The Editorial Board held two meetings during the past year. On July 8, 1970, the Board reviewed JOURNAL expenses and noted that not only local but national advertising income dropped in 1970. The hope was expressed that with the change in advertising agencies in November 1970, local advertising income would increase. (Ruehl and Co., Inc. has agreed to accept a 20% lower commission than the previous advertising agent, Sally Ladin Ogden Advertising Agency.) National advertising income has increased over the previous year, and it is hoped that this trend will continue. After comparing the bids from several printing companies who have recently quoted on the JOURNAL, the Board agreed to stay with the present printer. Although printing costs

are rising, the current printer's price is still below current bids. It was also decided to devote an issue of the JOURNAL to articles concerning the research and development of drug companies. Hopefully, this would promote more national advertising. Dr. Flotte decided to solicit manuscripts from several drug companies that advertise in the JOURNAL. However, there have been only three positive replies so far.

The terms of E. T. Lisansky, MD, and Edward C. H. Schmidt, MD, expired at the end of 1970. However, both were nominated and accepted reappointments to the Board.

The second meeting of the Board was held on March 22, 1971 to discuss the future of the JOURNAL and the deficit it continues to incur. At the request of the Board, the comptroller presented the breakdown of JOURNAL expenses for the past year, and pointed out that much of the large deficit is attributed to the directory that was published early in 1970 and the commissions paid to both the national and the local advertising agencies. Since a directory was not published this past year, this year's deficit will hopefully be significantly less. Once again, the Board voted to stay with the present printer, since all other bids submitted have been significantly higher.

The Board also discussed making the JOURNAL a quarterly or bimonthly. However, since many of the national advertisers would withdraw their advertising, and revenue would thus decrease, the deficit and expenses would not be reduced. The question of abolishing the JOURNAL altogether was also rejected, since the Faculty still needs a medium to communicate its news and events. Therefore, the Board agreed to retain the JOURNAL in its present monthly form, but suggested that the number of pages be reduced.

Mr. Al Rochfort, from the Ruehl and Co., Inc. advertising and public relations firm, presented an overview of the local advertising picture and suggested changing the format and updating the type face and style to attract new advertisers. He noted that our advertising rates, both nationally and locally, were fairly standard and advised against raising the rates at the present time. The Board also discussed adopting a standard cover for the JOURNAL, but agreed to retain a different cover every month for six months before reviewing a breakdown on the cost for a standard cover.

We are once again suffering from a shortage of manuscripts. It is hoped that through the efforts of the Editorial Board, members of the Faculty, and various specialty groups, we can find new sources for scientific material.

The JOURNAL continues to receive favorable comments on its appearance, and especially on the different covers each month. We are also continuing to reach a significant portion of the membership.

Respectfully submitted,

C. THOMAS FLOTTE, MD, *Editor*  
DEBBY ANDERSON, *Managing Editor*  
*Editorial Board*

LEON W. BERUBE, MD  
WILBUR R. ELLIS, JR., MD  
EDWARD S. KLOHR, JR., MD  
E. T. LISANSKY, MD  
EDWARD C. H. SCHMIDT, MD  
J. B. ZACHARY, MD



## MARYLAND STATE SCHOOL HEALTH COUNCIL

### Report of the Faculty Representative

*Mr. President and Members of the House of Representatives:*

As the official representative of the Medical and Chirurgical Faculty to the Executive Board of the Maryland State School Health Council, I am submitting the following information for your attention.

Approximately one year ago, the Maryland State School Health Council was asked to look into the implementation of Section 84, Article 77, of the Public School Laws of Maryland. This section has to do with the responsibility for making immunization against certain diseases compulsory prior to entrance into school.

A year-long study was made by the Health Services Committee of the Maryland State School Health Council, whose chairman was Julius Loeb, MD, Director of Maternal and Child Health in the Anne Arundel County Health Department.

The committee made the following recommendation: "Immunization against DPT, poliomyelitis, Rubeola, and smallpox should be made compulsory prior to entry into school in Maryland." This recommendation was thoroughly discussed and approved by the Executive Board of the Maryland State School Health Council. In addition to the Committee Members, Howard W. Garber, MD, Chief of the Communicable Diseases Division of the Maryland State Department of Health, Mr. Wayne Bobbitt, Immunization Project Coordinator, and John Pitts, MD, Director of Maternal and Child Health for the Maryland State Department of Health, were used as consultants.

It was the opinion of the committee that the first year that the regulations are in effect should be a period of grace to allow phasing in of the operation. Rubella was specifically omitted from the list of compulsory immunizations because of the recent difficulty with reactions in the mass campaign. It was felt that the phase-in period will be difficult enough without this added complication. After the program has been in operation for some time, other immunizations can be added as needed, such as rubella and mumps, or any other vaccine which becomes available. In addition to this, if nationwide experience in the future determines that any of the recommended compulsory immunizations should be discontinued, it will be quite easy to do this.

These recommendations will be forwarded to the Maryland State Department of Education and the Maryland State Department of Health and Mental Hygiene. It is their function to then hold hearings according to Article 41 of the Annotated Code of Maryland and make the final determination regarding this Advisory Committee's recommendations.

Respectfully submitted,  
MARGARET L. SHERRARD, MD,  
*Medical and Chirurgical Faculty Representative*  
*Maryland State School Health Council*

## MEDIATION COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Mediation Committee has met almost monthly during the past 12-month period. Agendas are lengthy, discussion is lively and protracted, and decisions are reached with remarkable clarity.

A summary of the total number of cases handled within the committee and by component medical societies throughout the state is attached to this report.

The committee has made several recommendations to the Commission on Medical Discipline for revocation, suspension, probation, or reprimand of physicians in Maryland for various acts. Some of these cases are still pending with the commission.

Many of the cases being considered by the committee come within the provisions of the Medical Practice Act regarding advertising. All advertising, except for certain specified actions, is prohibited under Maryland law. Despite information circulated to all members and to newly licensed physicians, the committee is still devoting much time to solving these problems. We do not know of any other solution except what is currently being done.

During the year, the case of Ghulam M. Nasim, MD, was finally disposed of by the courts. The court upheld the action of the Board of Medical Examiners in revoking his license. The original case, pursued by this committee, dates back several years.

Besides disputes appealed to the Faculty or handled on an original basis because the physician was not a member of a component society, the committee considered the following matters:

1. Determined that publication of a physician listing in the Columbia (city) Directory would be illegal under present laws and regulations.
2. Adopted guidelines for public announcements involving physicians. These essentially follow those promulgated by the AMA.
3. Adopted jointly with the Hospital Council, policies on publicity to be followed when recruiting individuals for mass screening surveys or research programs.
4. Investigated physicians using lesser-trained persons in the practice of medicine. In some cases, physicians have not been verifying the capability of such persons and have been designating responsibilities to them beyond their training and ability. In this same connection, the committee adopted a report of a subcommittee that sets policy guidelines for individuals to follow. These guidelines also establish procedures for payment by third parties for such services.
5. Heard several cases, both directly and through its Subcommittee on Medical Treatment and Drug Programs, of physicians who (a) are drug addicts or (b) are prescribing what is deemed to be inappropriate amounts of both narcotics, stimulant-depressant drugs. In some of these cases, recommendations were made to the Commission on Medical Discipline, with others still pending within the committee. The committee is gravely concerned over the number of physicians in this category, and



is doing its best to take appropriate action where indicated.

6. Advised and suggested changes for ethical reasons in contracts that were brought to its attention, mostly involving hospitalized service cases, or for care provided in hospital emergency rooms.
7. Discussed, at the request of the Howard County Medical Society, full-page advertisements promoting the Columbia Medical Plan, in the new city of Columbia. Appropriate guidelines are currently being developed by the Howard County Medical Society and representatives of the Columbia Plan.
8. Approved ethical guidelines for kidney dialysis and transplantation, after suggested changes were made.

The Subcommittee on Medical Treatment and Drug Programs remains active and is currently developing an Emergency Drug Treatment manual. This subcommittee

has worked closely with state and local officials in areas of mutual concern. In addition, members have been asked to appear before the Baltimore Grand Jury, as well as legislative committees and official bodies of local governments.

Respectfully submitted,

LEWIS P. GUNDRY, MD, *Chairman*  
 KATHERINE H. BORKOVICH, MD  
 ROBERT GOLDSTEIN, MD  
 LOUIS J. KOLODNER, MD  
 HENRY C. MELLETTE, MD  
 CHARLES F. O'DONNELL, MD  
 HILARY T. O'HERLIHY, MD  
 ROLAND T. SMOOT, MD  
 WILLIAM J. SULLIVAN, MD  
 HENRY C. WELCOME, MD  
 ROBERT V.L. CAMPBELL, MD  
 J. MORRIS REESE, MD  
 RICHARD D. BAUER, MD  
 ARTHUR G. SIWINSKI, MD  
 RUSSELL S. FISHER, MD

Component	Total Complaints	Complainant (SETTLED)	Defendant	Mutually	Pending 12/31/70	No Action	Referred to Med-Chi	Remarks
<b>Allegany County</b>								
Anne Arundel County	12	1	9	2	0			
Baltimore City	97	3	45	26	19		4	
Baltimore County	33	2	27	1	0		3	
<b>Calvert County</b>								
<b>Caroline County</b>								
Carroll County	4			4	0			
Cecil County	0							No complaints
Charles County	3			3	0			
<b>Dorchester County</b>								
Frederick County	1			1	0			
<b>Garrett County</b>								
Harford County	1			1	0			
Howard County	1		1		0			
Kent County	0							No complaints
Montgomery County	68	6	32	17	13			
Prince George's County	32	2	26	1	0	2	1	
Queen Anne's County	0							No complaints
St. Mary's County	0							No complaints
<b>Somerset County</b>								
Talbot County	0							No complaints
Washington County	5	1	4					
Wicomico County	2		2					
Worcester County	1			1				
<b>TOTAL</b>	<b>260</b>	<b>15</b>	<b>146</b>	<b>57</b>	<b>32</b>	<b>2</b>	<b>8</b>	

The Faculty considered a total of 62 cases of unethical activity on the part of physicians. Of this total, 37 cases were resolved; 14 cases were referred to the Commission on Medical Discipline; and 11 cases were still pending as of December 31, 1970.



## MED-CHI INSURANCE TRUST

*Mr. President and Members of the House of Delegates:*

The Med-Chi Insurance Trustees have continued in their efforts to obtain the very best insurance programs for Faculty members. As a result, most of the programs now offer increased or additional benefits, or decreased rates, or both. The programs administered by the Trust are: (1) Accident and Sickness Disability Insurance (2) Major Medical Expense Insurance (3) Blue Cross and Blue Shield (4) Business Disability Insurance (5) Regular Term Life Insurance (6) Decreasing Term Life Insurance, and (7) Keogh Retirement Plan.

The *Accident and Sickness and Major Medical* programs underwritten by the Hartford A & I Company have been very successful, due in part to close control by the Trust. The Trustees have approved the following policy changes which will be effective in 1971: increase daily private room and board to \$80; increase the maximum Major Medical benefit to \$35,000 on policy No. AGP1063, and increase coinsurance on policy No. AGP1064 to 90%; include a 10% "claim bonus" provision whereby all disability income claims occurring on or after the effective date would be increased 10%; provide limited coverage to an insured who is disabled while piloting an aircraft; provide a maximum benefit of \$15,000 for insured persons who are confined in an institution which is maintained for the treatment of mental disorders; and provide a conversion privilege to an insured member under age 60 in the event that the group policy is cancelled.

The *Blue Cross and Blue Shield* group has been changed to a 70-day plan with diagnostic coverage. The rates of our program are competitive with other groups, so that it is advantageous to most Faculty members to belong to the Faculty plan. Medical assistants of Faculty members are now eligible for participation in the group.

The *Business Expense Disability* program underwritten by The St. Paul Insurance Company has increased its number of subscribers. The limit of coverage was increased to \$1,500 a month in 1970.

The *Life Insurance* program underwritten by the Minnesota Mutual Life Insurance Company has been substantially improved. Premium rates were decreased across the board. In addition, the limit of coverage was raised from \$20,000 to \$50,000.

The *Decreasing Term Life Insurance* program underwritten by the Occidental Life Insurance Company is brand new. This provides up to \$100,000 of coverage at very low rates. It is valuable to members who wish to supplement their other life policies or who have purchased equipment or facilities and need higher coverage. This plan offers many benefits not found in other policies, including a conversion privilege.

The number of participants in the *Med-Chi Members Retirement Plan* increased significantly during 1970. As of the end of the year, there were 617 participants in the plan. The Equity Fund of the plan at year end was \$2,070,191. The unit value was 1.244.

It was a most successful year for the Trust. Our desire is to constantly maintain financially sound and economical programs which will warrant the continued enthusiastic support of the Faculty members.

Respectfully submitted,

PAUL F. GUERIN, MD, *Chairman*  
HARRY J. CONNOLLY, MD  
WILLIAM J. MCCLAFFERTY, MD  
RICHARD F. MOSCHELL, MD  
ALFRED S. NORTON, MD  
RICHARD ATLEE YOUNG, MD

## COMMISSION ON MEDICAL DISCIPLINE

*Mr. President and Members of the House of Delegates:*

The Commission on Medical Discipline is composed of the following members whose terms expire on the dates indicated:

Manning W. Alden, MD	.....1971
Charles Bagley, III, MD	.....1971
Henry A. Briele, MD	.....1971
Archie R. Cohen, MD	.....1971
John M. Dennis, MD	.....1972
Elmer G. Linhardt, MD	.....1973
Eli M. Lippman, MD	.....1972
Karl F. Mech, MD	.....1972
Uthman Ray, Jr., MD	.....1971

Members of the Commission are:

The President of the Medical and Chirurgical Faculty  
Three members of the Board of Medical Examiners  
The Chairman of the Council of the Medical and Chirurgical Faculty

Two practicing physicians appointed by the Secretary of Health and Mental Hygiene, selected from a list of nominees submitted by component societies of the Medical and Chirurgical Faculty

Two other licensed practicing physicians in Maryland, appointed by the Secretary of Health and Mental Hygiene

The term of Elmer G. Linhardt, MD, expired on July 1, 1970. He was reappointed to serve on the Commission through July 1, 1973.

The terms of Russell S. Fisher, MD, and John F. Schaefer, MD, expired on July 1, 1970, since their terms on the Medical and Chirurgical Faculty expired at that time. Henry A. Briele, MD, and Manning W. Alden, MD, were elected to serve on the Commission for the year 1970-71, since they are the present President and Council Chairman of the Medical and Chirurgical Faculty, respectively.

A total of 23 cases was referred to the Commission on Medical Discipline of Maryland for the period July 1, 1969 through December 31, 1970.

**Pending**—Nine cases are being held pending by the Commission:

- Illegal abortions (2)
- Professional incompetency (3)
- Unprofessional conduct (2)
- Violation of narcotic laws (2)

**Reprimands**—Seven cases have been closed by the Commission, following reprimands:

**Medicaid Fraud (5)**—A formal hearing was held on November 27, 1970, to hear the cases of Shirley R. Clinton, MD, Evan A. Gilkes, MD, Hollis Seunarine, MD,



Simon H. Carter, MD, and Edward E. Holt, MD, on several charges:

- (1) Willful making and filing false reports or records in his practice as a physician
- (2) Willful misrepresentation in treatments
- (3) Gross, willful, and continued overcharging for professional services, including filing of false statements for collection of fees for which services are not rendered
- (4) Professional or mental incompetency

After hearing testimony on each case individually, it was decided to charge each physician with professional incompetency. Each physician involved was reprimanded by the Commission, and informed that a copy of the Findings of Fact, Conclusions of Law, and Order shall be filed with the Board of Medical Examiners of Maryland.

*Advertising (2)—G. R. Sadjadi, MD*—Dr. Sadjadi appeared before the Commission on May 7, 1970, with reference to his negligence in responding to the advertising charge by the Board of Medical Examiners and the Mediation Committee of the Medical and Chirurgical Faculty. Dr. Sadjadi stated that when he received the above mentioned letter, he had discontinued his practice at that address, and felt that this was sufficient, and did not answer the letter. It was the opinion of the Commission that he had been very negligent in ignoring both the Board of Medical Examiners and the Mediation Committee, and the Commission informed him that he should be prompt in replying to any organization of medicine in the future.

*Andrew S. Tegeris, MD*—The Commission considered the case of Dr. Tegeris who has been investigated for advertising with the Pharmacopathics Clinical Laboratories. The Mediation Committee of the Medical and Chirurgical Faculty had investigated the charges against Dr. Tegeris and decided that action on his part was not performed in malice and that he had made an honest mistake. The Mediation Committee recommended that no action be taken currently, but warned him that additional action of this nature would result in disciplinary procedures. The Commission on Medical Discipline accepted the opinion of the Mediation Committee.

**Revocation**—One license to practice medicine and surgery in Maryland was revoked:

*George H. Beck, MD*—A formal hearing was held on May 14, 1970, to hear the case of George H. Beck, MD, on a charge of addiction to narcotics in violation of Article 43, Section 145, of the Annotated Code of the Public General Laws of Maryland, as it existed prior to its repeal and reenactment by virtue of the Medical Discipline Act creating this Commission. Dr. Beck was found guilty of violation of Article 43, Section 145 of addiction to narcotics, and his license was revoked on June 25, 1970. This revocation was stayed and Dr. Beck was placed on indefinite probation upon satisfactory compliance with the following conditions:

- (1) voluntary surrender of Federal Narcotic Permit
- (2) participation in a planned program of therapy acceptable to the Commission with the receipt of quarterly reports from the attending physician

- (3) Dr. Beck shall report at quarterly intervals before the Commission.

Dr. Beck reported before the Commission on October 29, 1970, and gave satisfactory reports of his professional activities.

**Probation**—Two physicians were placed on probation by the Commission:

*Christopher Mendelis, MD*—A formal hearing was held on June 25, 1970, to hear the case of Christopher Mendelis, MD, on charges of unprofessional conduct registered by Mrs. Edith R. Gick. It was the opinion of the Commission that Dr. Mendelis was guilty of unprofessional conduct, and he was placed on probation for a period of two years and required to report to the Commission at three-month intervals.

*Milton J. Wohl, MD*—Dr. Wohl appeared before the Commission on May 7, 1970, to discuss his past narcotic problems. During the discussion with Dr. Wohl, the Commission members impressed upon him the necessity of keeping his regular appointments, and cooperating with Dr. Lisansky, who is to report at six-month intervals to the Mediation Committee of the Medical and Chirurgical Faculty. The Commission concurred in the decision of the Mediation Committee that Dr. Wohl should continue under the treatment of Dr. Lisansky and should be followed by the Mediation Committee. Dr. Wohl has since transferred to the care of Hyman Rubenstein, MD. Dr. Wohl appeared before the Commission on October 29, 1970, and gave satisfactory reports of his progress.

**Closed**—Four cases were closed by the Commission and no action was taken.

Respectfully submitted,

JOHN M. DENNIS, MD, *Chairman*  
MANNING W. ALDEN, MD  
CHARLES BAGLEY, III, MD  
HENRY A. BRIELE, MD  
ARCHIE R. COHEN, MD  
ELMER G. LINHARDT, MD  
ELI M. LIPPMAN, MD  
KARL F. MECH, MD  
UTHMAN RAY, JR., MD

## MEDICAL ECONOMICS COMMITTEE

*Mr. President and Members of the House of Delegates:*

More than one meeting a month was held during the past year with major emphasis placed on the costs of professional liability insurance for physicians and discussion of alternative methods of providing such coverage.

A summary of the various alternatives is attached to this report. In all cases, the committee's recommendations were accepted by the Council.

Following the 1970 Annual Meeting, the committee was presented with actuarial data from The St. Paul Companies which indicated the necessity of an extensive rate increase effective July 1, 1970. Because there was not adequate time to analyze this material, the committee recommended to the Council that it:

1. Endorse the rate increase request made by The St. Paul Companies to the Insurance Commissioner;
2. Authorize employment of an independent actuary



to analyze and present data confirming or disputing the statistical information provided by The St. Paul Companies;

3. Authorize the expenditure of funds to analyze the professional liability situation in the state of Maryland over the past ten-year period.

All of these requests were approved by the Council.

At one of its most recent meetings, the committee was again presented with data that indicates the necessity of another extensive rate increase effective within the next few months. The committee has declined to make any recommendation in this regard, pending analysis of the data by the Actuary employed to analyze the previous year's data. When this report was written, this matter was still pending before the State Insurance Department.

The information provided a year ago, together with additional information provided by The St. Paul Companies to the Actuary, indicate the necessity of last year's rate increase if the company is to stay in the professional liability business in Maryland.

In other related matters concerning professional liability insurance, the committee chairman, together with Faculty legal counsel, have continued to visit and talk with hospital medical staffs regarding the mechanisms that can be used to prevent malpractice actions.

The committee reported to The St. Paul Companies that the panel system is not being used extensively in the Montgomery and Prince George's areas of the state. They agreed that it was important for this type of expert medical advice to be used, and emphasized that it should be used wherever and whenever possible.

The committee also agreed with a proposal of The St. Paul Companies that liability be limited to \$100,000/\$300,000 on all policies issued by that company; with excess over this amount to be carried through an umbrella-type coverage available through The St. Paul Companies, if physicians wished to have such additional coverage. The Council declined to endorse this concept, receiving it for information only.

The committee is still actively considering a proposal as suggested by the Actuary, that a surpool type of insurance program be developed that is best described in the subcommittee report presented to the full committee late in the Faculty year. This is as follows:

The Subcommittee recommends that the committee consider the total picture by dividing it into two phases. The first phase would deal with the business or economic aspect of providing coverage. Essentially, the carrier should be involved in making determinations on an actuarial basis as to the costs of providing insurance, as well as its profit picture. Of major importance also, which the carrier has expertise in, is the question of investigation of cases, as well as qualified persons to handle the management and underwriting situations that arise.

The Faculty should then involve itself in the underwriting or professional side of the picture. It is here that the Faculty can assist the carrier immeasurably.

It is recommended that representations be made to The St. Paul Company that:

1. The Faculty assist St. Paul in selection of individuals who seek insurance through the Faculty-endorsed

program by providing data and information from its files in this regard and generally assisting in selection of good underwriting risks.

2. That the method of calculating premiums be changed so that the Surpool concept be implemented. By this we mean that there be a basic charge for coverage, supplemented by a percentage figure based on a RVS schedule. For instance, any RVS schedule could be utilized and a coefficient factor be developed for different areas of the state. A percentage would then be charged on the number of procedures performed times the computation developed from the RVS and its conversion factor.

For instance, an appendectomy could be 100 on the relative value scale. For the Eastern Shore, a conversion factor of \$2 would be used. For the metropolitan Baltimore area, a conversion factor of \$3 could be used.

The physician from the Eastern Shore be assessed a percentage of each appendectomy (or any other procedure) based on \$200 for each appendectomy. The Baltimore area physician be assessed on the basis of a percentage of the total appendectomies performed times the \$300 figure.

3. Standards be developed so that physicians can be categorized as to their abilities and the extent of the procedures they can perform. This may be difficult, but it should be attempted.

The committee has continued to make determinations for third-party carriers when the amount of the Usual and Customary fee for medical services is in dispute. A total of ten cases has been reviewed with four being found for the physician and six being found as higher than what is considered usual and customary for the community.

The committee heard three cases of appeal from the decision of St. Paul with respect to continued coverage under the Maryland program of professional liability. In all cases, the committee concurred in the decision of the carrier that the policies not be renewed.

The committee has heard of considerable dissatisfaction over policies of Blue Shield with respect to determination of a physician's profile; unsatisfactory communications by Blue Shield with patients; and other related matters.

As a result, the committee recommended that a questionnaire be sent to all members of the Faculty to ascertain whether or not dissatisfaction exists with Blue Shield throughout the entire state. This was approved by the Council.

Your committee is studying in great detail the ever-increasing costs of professional liability insurance. While it does not anticipate any easy solution to this problem, it will continue to grapple with it and do the best it can in this regard for the membership.

#### **Proposals on Malpractice Alternatives (Screening Panels) Secretary of Health Proposal**

This proposal is similar to programs that have been adopted throughout the country. Some have been successful, particularly those in small communities where there is a more personal relationship between the physi-



cians and attorneys and where the patient is well known by the entire community.

In larger areas, such as Philadelphia and New Jersey, they have not been successful. Legal counsel has indicated that this will not result in any diminution of malpractice actions, but may well increase them.

There is no assurance that the patient will not seek the services of another attorney and institute suit, even if the panel agrees that no cause exists for such a suit. Data and information made available to the attorney for the plaintiff can also be used against the physician, which is undesirable especially in the adversary situation that exists today.

There is also some question as to whether the professional liability insurers would agree to such arbitration. The company now insuring physicians in Maryland, in a cooperative arrangement with the Faculty, might well agree to discontinue such arrangement. If this occurred it would make it extremely difficult for physicians to obtain coverage, inasmuch as many companies are declining to write this type of insurance.

The committee agreed to recommend that this proposal not be accepted as a desirable one because of the many problems involved, not the least of which is its questionable acceptance by the Bar Association and particularly the Plaintiff's Bar Association.

#### **Legal Counsel Proposal**

The committee then considered the proposal of Mr. John King, legal counsel, which would establish an arbitration panel composed of one physician selected by the patient and one selected by the attending physician. These two would select an attorney and, if one could not be agreed on, the president of the State Bar Association would serve or designate an attorney to serve. This latter person would act as chairman.

The patient would have to sign an arbitration agreement prior to receiving medical care so that such arbitration would be binding under the law.

The committee unanimously agreed that this type of proposal should be rejected. Not only would it, in their opinion, result in more cases, but it would destroy the confidence the patient has in his physician and it could lead to further deterioration of the traditional physician-patient relationship.

The committee was also of the opinion that this might be pursued for those "service" patients where no such physician-patient relationship existed. It should be discussed with the Hospital Council, and the committee so recommends that the Executive Committee pursue this.

#### **Workmen's Compensation Type Program for Malpractice**

A proposal was presented in which each case presented by a patient claiming malpractice would be heard by a commission (similar to the present Workmen's Compensation Commission) and subject to a set schedule of recovery rates.

Mr. King, legal counsel, foresaw a difficulty in the latest plan offered, in that the claimant would be obliged to give up a jury trial and allow decision on recovery and the amount to be decided by a commission. In addition, under such a plan there is no concept of fault. Whenever the patient has a bad result, he would be entitled to compensation. The medical profession deals

with sick people to begin with, and it is difficult to envisage compensation just because they are not cured. It may be that some sort of standards could be set up, but this probably would drive the costs even higher.

The question was asked whether fault could be found by a jury and recovery determined by a commission. This was considered possible, but not pursued further. It was pointed out that of some \$80 million a year collected in premiums in the United States on behalf of physicians for professional liability, only about \$20 million goes to the patient. The balance is used for legal fees, and goes into reserves and for administration expenses.

The committee agreed that it was impractical for the reasons indicated to pursue this further.

#### **Professional Economic Services**

W. Arthur Bingham and I. David Gordon of the Professional Economics Services were present for the first portion of the meeting as guests. Their purpose was to discuss professional liability with the committee. Mr. Gordon outlined the difficulties being experienced in other states in keeping down rates and even in obtaining professional liability insurance. His company is a finance service corporation, a subsidiary of John Hancock. They provide financial planning services of all types to physicians and dentists. Professional liability insurance is just one area of their operation. Mr. Gordon explained a plan being tried in other states of setting up physician-owned insurance companies. While this plan is comparatively new, it seems to have some good possibilities. He explained that none of the ten leaders in the professional liability insurance field who were questioned kept statistical data showing gross premium income including investment income vs group cost and claim and expense outgo. Many carriers are withdrawing from underwriting this type of coverage. Professional Economic Services offers a retrospective rating plan for professional liability insurance. The plan will establish a fixed dollar insurance premium. If, including investment income, the insurer earns money on the program, it will return a dividend to the physicians. If the insurer loses money there will be a fixed maximum increase, usually 10%.

The program would be audited over a ten-year period. There would be two requirements of this program: (1) the insuring company could not be used by members for their personal use; and (2) members must abide by decision of insurer whether to settle or not. It is estimated it would take one-half to one million dollars to form an insurance company. Mr. Gordon and Mr. Bingham were thanked for their interest and time and told that the committee would be in touch with them at a later date after results of the current professional liability study are known.

It was determined that the proposal as advanced by Professional Economics Services should not be pursued further because it was evident that the group involved was primarily a capital funding operation, the benefits of interest on money loaned being its prime source of income.

#### **Compensation Concepts, Inc.**

The following persons were present for a discussion



regarding a proposed program for professional liability insurance: W. Harold Leonhart, William M. Flattery, and Richard Colonell.

After detailed presentation of the professional liability problem and suggested solutions to this problem, there was a general discussion regarding specifics.

It was emphasized that the Faculty's Medical Economics Committee had this suggestion under discussion for some time and that it was not original with those making the presentation. In addition, in response to a specific question, the only role that this group would play would be (a) to act in a consultant capacity by endeavoring to locate individuals who would be employees of the Faculty or a corporation to operate the program and (b) to play a role in obtaining reinsurance for the program.

This group had a more logical proposal to offer but it was rejected on several grounds. The first was that reinsurance as proposed by this group is not necessarily always available or, if it is, it is available at rates that could quickly force any wholly-owned and self-operated program to go bankrupt within a short time.

Principle to this discussion was the question of extensive losses that could occur within the first year or two of any such program operation. Such catastrophic losses would wipe out the assets of the company, as well as conceivably require an assessment on the policy holders.

In an in-depth study conducted by the California Medical Association in 1968, the following was stated and is valid for the state of Maryland as well:

"Reinsurance is a method by which an insurance company controls the amount of risk it believes that it is capable of assuming relative to its own financial structure. Because of the minimal financial strength of the new carrier, its risk retention capacity would necessarily be low. It would be necessary for the new carrier to purchase large amounts of reinsurance. Companies involved in the provision of reinsurance are in business to earn a profit. They are, in effect, purchasing earnings over an extended period of time through the potential use of their moneys . . . recognizing (from the reinsurers standpoint) that a new minimally funded carrier in the loss plagued field of malpractice insurance has at least 2.9 strikes against it to begin with, it is a certainty that adequate reinsurance facilities would be virtually impossible to secure at a reasonable price, if at all."

It can be argued that the regular line companies have no difficulty in obtaining reinsurance. However, these regular line companies also have assets from the provision of other lines of insurance offered to physicians, as well as the general public.

This brings us to the second important point for rejection of the proposal as offered by Compensation Concepts. Regular line companies have millions of dollars in their portfolios and reserves. If they sustain any large loss in one field, they can suffer this loss without undue hardship, taking it from their total reserves accumulated from all fields of insurance. Any company organized through Faculty auspices would not have such sums of money to fall back on.

Brief consideration was given to the possibility of a state-funded program, but this was rejected because of the controls, as well as political considerations that would have to be involved.

Respectfully submitted,  
W. KENNETH MANSFIELD, MD, *Chairman*  
ARTHUR BAITCH, MD  
J. TYLER BAKER, MD  
FRED COLE, JR., MD  
DAVID CRAWFORD, MD  
SAMUEL M. M. LUMPKIN, MD  
PHILIP W. MERCER, MD  
ALFRED S. NORTON, MD  
HANS WILHELMSSEN, MD  
DANIEL BARTELL, DDS

## COMMITTEE ON MEDICINE AND RELIGION

*Mr. President and Members of the House of Delegates:*

Just one meeting of the Committee on Medicine and Religion was held during the year. This was held in conjunction with the Semiannual Meeting of the Faculty in Hershey, Pennsylvania in September 1970.

At this meeting, Mr. Arne Larson of AMA's Department of Medicine and Religion described some current activities of the AMA and other state societies in the field of medicine and religion. A guide has been developed by AMA to help medical societies develop courses on medicine and religion in the medical schools. In addition, every seminary in the country has been contacted concerning courses in medicine and religion; great interest has been shown.

The Johns Hopkins has an active program in medicine and religion which your chairman described.

The main activity of the year, however, has been in producing a panel symposium on the "Treatment of the Alcoholic and the Family—Practical Aspects," during the Annual Meeting at the Civic Center. Besides local luminaries, Dr. Richard K. Young, Professor of Pastoral Care, Southeast Baptist Theological Seminary, Wake Forest, North Carolina, was a special guest panelist. The panel was directed primarily to clergymen, seminary students, medical, and nursing students. Attendance was excellent and a stimulating program ensued.

Respectfully submitted,  
MARTIN L. SINGEWALD, MD, *Chairman*  
LEO H. BARTEMEIER, MD  
DOUGLAS CARROLL, MD  
ROBERT W. FARR, MD  
KENT R. FIEDLER, MD  
DONALD MINTZER, MD  
WM. R. O'ROURKE, MD  
WM. H. PATRICK, MD  
JAMES A. ROBERTS, MD  
ELIJAH SAUNDERS, MD  
GEORGE M. SIMONS, MD  
ROLAND SMOOT, MD  
SIDNEY VENABLE, MD  
HUGH WARD, MD  
JACK MCKAY ZIMMERMAN, MD

## MEDICOLEGAL COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Medicolegal Committee held one meeting during the year ending July 1, 1971. Assignment of subcommittees took place at the first meeting.

An assignment and medical report form was approved by the committee and submitted to the Maryland State Bar Association for approval. However, it was not



approved by that group, and was sent back for clarification of certain points. The form has now been officially approved by this committee, but no further action has been taken by the Bar Association.

#### Subcommittee on Interprofessional Relations

There were two meetings of this subcommittee, which considered many disputes between attorneys and physicians.

Members of both professions are still confused about the Medicolegal Code of Cooperation insofar as payment for medical reports is concerned. A concerted effort will be made in the following year to clarify this in the code.

Discussion of payment for psychiatric evaluation done at the request of attorneys was discussed. It was agreed that it was ethical for a physician to require immediate payment from an attorney upon receipt of a consultative report, and that such fees can properly be advanced by the attorney as costs, with the understanding that the amount is reimbursable by the client-patient.

#### Symposium Subcommittee

One symposium was held by physicians for attorneys during the mid-winter meeting of the Maryland State Bar Association. The symposium was held in the format of a "mock" trial on the subject of back injury. The meeting was extremely well attended and well received.

Respectfully submitted,  
 CONRAD ACTON, MD, *Chairman*  
 ROBERT W. JOHNSON, III, MD  
 HOWARD F. KINNAMON, MD  
 J. ELLIOT LEVI, MD  
 BELDEN R. REAP, MD  
 WILLIAM D. BOYD, MD  
 JOHN F. STRAHAN, MD  
 JAMES D. DRINKARD, MD  
 PAUL E. HUFFINGTON, MD  
 RUDIGER BREITENECKER, MD  
 CLINTON R. HARRISON, MD  
 JONAS RAPPEPORT, MD  
 RAYMOND V. RANGLE, MD  
 JAMES R. KARNS, MD  
 HARRY G. RANDALL, III, MD

### NOMINATING COMMITTEE

*Mr. President and Members of the House of Delegates:*

The following names are being presented for your consideration for election to office. Those elected will assume office at the conclusion of the 1972 Annual Meeting, unless otherwise indicated.

#### President-elect

DeWitt E. DeLawter, MD, { President-elect 1971-72  
 Bethesda { President 1972-73

#### First Vice President

Edwin R. Ruzicka, MD, Easton (1973)

#### Second Vice President

Katherine H. Borkovich, MD, Baltimore (1973)

#### Third Vice President

Manning W. Alden, MD, Annapolis (1973)

#### Secretary

William A. Pillsbury, MD, Timonium (1973)

#### Treasurer

Karl F. Mech, MD, Baltimore (1973)

#### Councilors

##### Central District

Louis J. Kolodner, MD, Baltimore (1975)

Louis J. Kolodner, MD, Baltimore (1971-72)

(to fill unexpired term of Robert C. Kimberly, MD, resigned)

##### South Central District

Frederick E. Musser, MD, College Park (1975)

##### Southern District

Elmer G. Linhardt, MD, Annapolis (1975)

##### Western District

Richard Y. Dalrymple, MD, Westminster (1975)

Robert J. Thomas, MD, Frederick (1975)

#### Delegate to the American Medical Association

Robert vL. Campbell, MD, Hagerstown

(Jan. 1, 1972—Dec. 31, 1974)

#### Alternate Delegate to the American Medical Association

William Carl Ebeling, MD, Towson

(Jan. 1, 1972—Dec. 31, 1974)

#### Committee on Program and Arrangements

Edwin H. Stewart, MD, Baltimore (1972-76)

#### Library and History Committee

Katharine A. Chapman, MD, Kensington (1972-77)

#### Finney Fund Committee

D. C. W. Finney, MD, Baltimore (1977)

#### Board of Medical Examiners

J. Roy Guyther, MD, Mechanicsville (June, 1971-June, 1975)

Gerald A. Galvin, MD, Baltimore (June, 1971-June, 1975)

Respectfully submitted,  
 RUSSELL S. FISHER, MD  
 Baltimore, *Chairman*  
 HARRY F. KLINEFELTER, MD  
 Baltimore, *Central District*  
 AARON H. TRAUM, MD  
 Silver Spring, *South Central District*  
 RICHARD A. JONES, MD  
 Westminster, *Western District*  
 ARTHUR O. WOODY, MD  
 La Plata, *Southern District*  
 RAYMOND M. YOW, MD  
 Salisbury, *Eastern District*  
 WILLIAM A. PILLSBURY, MD  
 Timonium, *Member-at-Large*

### OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE

*Mr. President and Members of the House of Delegates:*

Two meetings of this committee were held under the chairmanship of Carlos Villafana, MD. A number of pertinent topics were discussed and some action was taken.

The committee selected "Multiphasic Screening in Industry" as its topic for the round-table discussion at



the annual meeting. It also expressed interest in obtaining an industrial exhibit for this meeting.

A series of articles to be included on a special Occupational and Environmental Health page in the *Maryland State Medical Journal* was assured by the committee members. The articles will appear bimonthly.

Questionnaires mailed to all Faculty members concerning their interest in industrial medicine drew a good response. The questionnaires are now being compiled by geographic location and specialty of the physicians replying. The Chamber of Commerce is also being contacted for a list of industries and a request to disseminate, through its monthly bulletin, information that medical placement assistance is available.

The committee felt that the award by the Governor's Committee on Employment of the Handicapped should go to a physician who is actively practicing industrial medicine. The Maryland Industrial Medical Society will be requested to submit such a name for nomination next year.

Other topics discussed during the year included pollution of beaches and pools, and pre-employment screening for drugs in industry and ways that the physician can help those who use drugs.

Respectfully submitted,  
CARLOS VILLAFANA, MD, *Chairman*  
HAROLD Y. ALLEN, MD  
WALTER E. FLEISCHER, MD  
JAMES FRENKIL, MD  
HERMAN J. HALPERIN, MD  
DONALD J. ROOP, MD  
ROBERT BRANDT, MD

## PEER REVIEW COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Peer Review Committee has met on a monthly basis since its inception. It has developed guidelines for local peer review committees, has established a regional organization for component societies that are too small to warrant peer review committees of their own; and has cooperated with insurance carriers in developing data for the committee's use.

In addition, it has handled a total of 15 individual cases, referred several cases to local components for review, and has urged third party payors and other sources to send data for review by the committee.

While this report may be short, it does not adequately speak of the many hours of work performed by its members.

Respectfully submitted,  
ARTHUR E. COCCO, MD, *Chairman*  
RICHARD C. ARBOGAST, MD  
KATHERINE H. BORKOVICH, MD  
EARL C. CLAY, JR., MD  
JOHN R. DAVIS, MD  
ROBERT M. HEYSSEL, MD  
LEEDS E. KATZEN, MD  
WATSON P. KIME, MD  
HARRY F. KLINEFELTER, MD  
CHARLES H. LIGON, MD  
JOHN G. WISWELL, MD

## POLICY AND PLANNING COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Policy and Planning Committee held one meeting since the Faculty's last annual session.

At this meeting, the report of the AMA's Committee on Planning and Development was discussed item by item. Recommendations were made to the Council in this regard and a complete summary of the action taken at this Council session was reported in the July issue of the *Maryland State Medical Journal*. This information was communicated to the Faculty's delegates to the AMA House of Delegates for its information and guidance when this subject was discussed by the AMA House of Delegates.

Respectfully submitted,  
ARTHUR T. KEEFE, JR., MD, *Chairman*  
JULIUS LOEBL, MD, *Vice-Chairman*  
HENRY A. BRIELE, MD  
JOHN F. SCHAEFER, MD  
WILLIAM A. PILLSBURY, MD  
KARL F. MECH, MD  
MANNING W. ALDEN, MD  
JOHN M. DENNIS, MD  
ROBERT J. DAWSON, MD  
KATHERINE H. BORKOVICH, MD  
JOHN C. HYLE, MD  
OSMAN Z. ERSOY, MD  
HAROLD B. PLUMMER, MD  
WILLIAM R. O'ROURKE, MD  
ROLAND A. NAJERA, MD  
J. PARRAN JARBOE, MD  
WILBUR N. BAUMANN, MD  
RICHARD L. FRUTH, MD  
HERBERT H. LEIGHTON, MD  
FREDERICK J. HATEM, MD  
GEORGE E. GROLEAU, MD  
HERMAN C. MAGANZINI, MD  
ROBERT D. DIETZ, MD  
JOHN SMITH, JR., MD  
ABDUSSAMED SAMADI, MD  
JAMES A. STERLING, MD  
J. TYLER BAKER, MD  
RICHARD T. BINFORD, MD  
CHARLES BAGLEY, III, MD

## COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH

*Mr. President and Members of the House of Delegates:*

This comprehensive committee, including its many and varied subcommittees, met regularly during the year and studied a number of pertinent and worthwhile projects.

Inasmuch as the majority of the committee activity takes place within the subcommittees, a summary of their activities is herewith presented.

### Subcommittee on Airport Medicine

As a result of a study done by this subcommittee, it was ascertained that of 10,478 airports in the country, only 322 have FAA towers. The subcommittee, recognizing that it would be impossible to control the piloting of planes by persons under the influence of alcohol, therefore determined that a recommendation should be made to the FAA suggesting that regulations in this area be developed and adopted. This recommendation



was made through an Ad Hoc Committee of the parent group, on initiation by this subcommittee.

Additional statistics obtained by the subcommittee indicate that in 1963, 48% of fatal plane accidents were due to alcohol; and that in 1968, 23% involved alcohol.

As a result, the Faculty communicated with the FAA, which has since adopted a regulation that an eight-hour interval rule be enforced for crew members of private aircraft consuming alcoholic beverages prior to flying.

Two other recommendations are under active study by the FAA. These are:

1. That an intensive educational program be adopted alerting crew members to the danger of mixing flying and alcohol.
2. That some type of "implied consent" or "express consent" regulation law be adopted for crew members of private aircraft.

The subcommittee is also considering the use of the SST in the United States and any effect this may have on the residents of airports where such planes would land and take off.

#### Subcommittee on Child Welfare

This subcommittee, on the request of the Department of Health and Mental Hygiene, arranged for an alert to be sent to all physicians regarding the use of penicillin ointment and antibiotics in newborn infants' eyes. This request from the department had been instituted following a similar communication addressed to all hospitals from the U.S. Department of Health, Education and Welfare.

In addition, the subcommittee recommended that the

#### Subcommittee on Alcoholism

This subcommittee's main activity has dealt with the problem of admitting alcoholics to general hospitals. It has continued its efforts to have all private rehabilitation facilities for alcoholics licensed so that the burden of treating such patients can be removed from general and other hospitals. At the present time, private insurance carriers, including Blue Cross, will not pay for treatment rendered in facilities that do not have some form of state licensure. To date, there has been little success in this area.

A communication has been addressed to the Secretary of Health and Mental Hygiene suggesting that some arrangements in this connection be made, but many roadblocks still exist in completing such a plan.

In other related activities, the subcommittee turned its attention to the problem of admitting alcoholic patients to VA hospitals; and insurance coverage arranged by one union in the state which excludes payment for treatment of alcoholics. Both of these subjects are being actively pursued.

Faculty approve the proposed regulations for day care centers, under study within the Department of Health and Mental Hygiene; discussed the question of all prescription labels containing information as to the contents (strength and medication); discussed whether or not all prescriptions should have child-resistant closures (tamper-proof caps); and started work on a policy statement dealing with the use of medication for children with learning disabilities.

#### Chronic Respiratory Disease Subcommittee

This subcommittee is still studying the problem of tuberculosis and the case-finding techniques in use within the city of Baltimore. This area has one of the highest incidences of tuberculosis in the United States. The subcommittee was instrumental in developing two messages in connection with air pollution. The first, directed to the public, was released to the press and advised in-

dividuals as to the procedures to be followed in the event of an air pollution emergency. The second, addressed to the physicians in the state, dealt with recommended treatment procedures for such patients in the event of such an emergency. Much favorable comment was received from the public and the communications media on these two activities of the Faculty.

#### Subcommittee on Emergency Medical Services

This subcommittee sponsored a most successful one-day symposium in March 1971, and more than 100 people were registered. The comprehensive program did much to attract attendance and also provided excellent press coverage for many problems in this area.

Many subjects were discussed within the subcommittee. These included establishing guidelines for transporting acutely ill patients by helicopter to the University of Maryland's Trauma Center; developing dialogue between representatives of Blue Cross, Blue Shield, the Maryland Hospital Association, and the Faculty regarding payments for nonemergency medical situations for which payment could be made by the carrier; and

adopting the following resolution, which was approved by the Faculty's Executive Committee:

**That it be recommended to the medical staffs of Maryland Hospitals that, in view of the opinion of the legal counsel for the Medical and Chirurgical Faculty regarding legal abandonment of patients, that they consider revising their bylaws to include the revocation or suspension, or alteration of hospital privileges, if a member physician uses the emergency department in a manner other than specified. This recommendation should be forwarded to the president or chief of staff, and administrator of every hospital in Maryland.**

The basis for this recommendation originally was because many physicians refer patients, by an answering service, to the nearest emergency department when they



are off duty. This happens in many hospitals in Baltimore city with physicians who do not have privileges. Such action by a physician is considered abandonment of a patient, and this recommended action may be one avenue to keep emergency departments from being overrun by nonemergency patients, and bring about the establishment of other facilities for such cases.

After a lengthy discussion, it was decided that this recommendation should be again taken back to the subcommittee, with the request that consideration be given to adding a more positive sentence urging the

hospitals to develop an alternative facility for primary health care when local physicians are not available to treat their own patients.

On recommendation of this subcommittee, the Faculty communicated its concern to the Secretary of Health and Mental Hygiene regarding licensure of ambulance attendants, as well as establishing minimum standards for ambulances throughout the state. A response has been received from the secretary indicating that this matter will be placed under active study and implementation by his department.

#### **Steering Subcommittee for Immunization Projects**

This special group was called together to develop guidelines and work closely with state agencies in the areas of immunization, where increasing emphasis and education is being placed.

Considerable concern has been expressed over the lack of response in some communities when rubella immunization proposals were offered to the public. The subcommittee recommended to the Council, which acted favorably on the recommendation, that a program in each political subdivision to immunize preschool backlog and other children up to 12 years be conducted at the earliest convenient time. This was developed and

took place in June 1970.

The group tabled a recommendation from the American Academy of Pediatrics that mandatory rabies vaccination of dogs and psittacine birds be approved. Such action was based on the practicality of the situation and the unenforceability of such a law.

Grave concern was expressed over the proposed regulations for immunization of children prior to entering school. These have been developed without consultation with the profession. The School Health Council was contacted and the proposed immunizations were obtained and reviewed by the committee.

#### **Subcommittee on Maternal Welfare**

Consideration was given to revising the Faculty Guidelines for Performance of a Therapeutic Abortion in the event that the U.S. Supreme Court rules all abortion laws to be unconstitutional. These have been developed and, in the event such should occur, will be submitted to the Council for its approval and dissemination throughout the state.

The subcommittee recommended to the Council, and the Council approved, that the provision regarding con-

sultation for performance of a therapeutic abortion be removed from the guidelines and that the Faculty adopt a policy consistent with JCAH regulations as they change.

Perinatal information has been received from the State Department of Health and is under continual study.

The subcommittee recommended and the council approved: that routine prenatal STS and rubella HIA tests be performed and that this be an official policy of the Faculty.

#### **Subcommittee on Continuing Medical Education (MEDIC)**

These programs are to be expanded and considerable thought has gone into acquiring more office space in a neutral location, but it was agreed that the office at the state office building would be retained until a move is necessary. Attendance at the regular Friday programs has been approximately 100, although many hospitals do not report their attendance. The chairman was heartened by the willingness of the members to sponsor

programs for the next year.

Other action, involving this subcommittee, includes the use of AMA tapes of the *Audio-News Journal* which are broadcast on Thursdays over the network.

The subcommittee has recommended that its name be changed from that of MEDIC to Subcommittee on Medical Education, which would include a broadening of its role in this area.

#### **Subcommittee on Medical Aspects of Sports**

The subcommittee sponsored another Seminar on the Medical Aspects of Sports. Attendance continues to be extremely good, because of the caliber of speakers se-

lected for these sessions. It is now becoming necessary to go farther afield to obtain qualified speakers and, thus, additional funds were sought from the Council.



A central registry for sports injuries is advocated by this subcommittee, and this subject is being actively pursued with the Department of Health and Mental Hygiene.

Still being developed are guidelines for weight loss

in interscholastic and collegiate wrestling; publicizing through all communication media the availability of "easy" physical fitness programs; and insurance coverage for interscholastic activities.

### Subcommittee on Traffic Safety

This subcommittee has spent considerable time on various proposals for increased safety on Maryland highways, the results of which in the past are now in effect in Maryland and for which large sums of federal money have been made available. A letter was sent to the Commissioner of Motor Vehicles recommending that all individuals 65 years of age and older be reevaluated

for vision and driver ability when applying for license renewal. The commission responded that this would be implemented when staff and facilities are available.

The subcommittee also expressed deep concern over the lack of enforcement of the Express Consent Law, primarily insofar as the medical aspects of accidents created by drunken drivers.

### Other Activities

In other activities, the committee is considering the appointment of a subcommittee to deal with human ecology; has maintained liaison with the Regional Medical Program; and has secured a small number of speakers for component society meetings.

The committee has been kept informed of the activities of the Maryland Consortium for Health Sciences through John B. De Hoff, MD, and has had regular reports from the representative of the Emotional Health Committee of the Faculty, who is also a liaison member of this committee.

The Joint Anesthesia Study Committee had expressed concern over an increasing lack of cooperation by hospitals in sending material for discussion and presentation at its regular meetings. This has been partly alleviated: the City Health Commissioner, a member of our committee, has contacted hospitals and urged them to continue the previous cooperation in this regard. This activity is extremely important, particularly in attempts to improve the quality of health care being provided to residents of Maryland.

The educational efforts of the committee have also received considerable attention. Attempts have been made to evaluate the effectiveness of the programs offered through the Annual and Semiannual Meeting sessions and liaison has been established with the Program and Arrangements Committee through joint membership.

The committee was also instrumental in obtaining the services of a special panel to advise the Department of Health and Mental Hygiene in respect to an alleged pollution problem in Cecil County. There is conflicting opinion with respect to whether or not this is affecting the health of certain citizens of that area.

It is extremely regretted that the chairman of this committee, who has served for several years in this capacity, was taken ill during his term of office.

Appreciation is expressed not only to Dr. Whitridge for his many years of loyal and devoted service to the Faculty, but also to his pro-tem successor, Robert E. Farber, MD, who assumed the chairmanship through the end of the Faculty year.

To Dr. Whitridge goes many thanks for his guiding spirit, enthusiasm and energy; to Dr. Farber, appreciation for a job well-done and filling in at a time of need.

Respectfully submitted,

JOHN WHITRIDGE, JR., MD, *Chairman*  
EDWARD DAVENS, MD  
JOHN B. DE HOFF, MD  
ROBERT E. FARBER, MD  
KARL M. GREEN, MD  
FRED J. HELDRICH, MD  
CLAUDE D. HILL, MD  
JOHN H. HIRSCHFELD, MD  
D. FRANK KALTREIDER, MD  
MILTON B. KRESS, MD  
JULIUS LOEBL, MD  
CALBERT T. SEEBERT, MD  
RAYMOND P. SRIC, MD  
PERRY STEARNS, MD  
JEAN R. STIFLER, MD  
RAMSAY B. THOMAS, MD  
LOUIS W. TINNNIN, MD

### Subcommittee on Airport Medicine

JULIUS LOEBL, MD, *Chairman*  
DONALD M. BARRICK, MD  
JOHN B. DE HOFF, MD  
ARIS T. ALLEN, MD  
JAMES E. TOHER, MD

### Subcommittee on Alcoholism

JOHN H. HIRSCHFELD, MD, *Chairman*  
CONRAD B. ACTON, MD  
EDMUND G. BEACHAM, MD  
STANLEY J. BOCIEK, MD  
JOHN R. DAVIS, MD  
IRENE L. HITCHMAN, MD  
ISADORE KAPLAN, MD  
HARRY F. KLINEFELTER, MD  
LEONARD M. LISTER, MD  
ABRAHAM M. SCHNEIDMUHL, MD  
ROLAND T. SMOOT, MD  
IRVING J. TAYLOR, MD  
MAXWELL N. WEISMAN, MD  
MR. L. WHITING FARINHOLT, JR. (*Advisory Member*)  
THE REV. HARRY E. SHELLEY (*Advisory Member*)  
MR. LUDWIG L. LANGFORD (*Advisory Member*)

### Subcommittee on Child Welfare

RAYMOND P. SRIC, MD, *Chairman*  
JOHN A. GRANT, MD



MURRAY M. KAPPELMAN, MD  
EDWARD J. KOENIGSBERG, MD  
LAWRENCE C. PAKULA, MD  
ROBERT E. YIM, MD  
BENJAMIN D. WHITE, MD  
JOSEPH J. McDONALD, MD  
MARGARET L. SHERRARD, MD

*Chronic Respiratory Disease Subcommittee*

MILTON B. KRESS, MD, *Chairman*

*Subcommittee on Emergency Medical Services*

JOHN B. DE HOFF, MD, *Chairman*  
GEORGE H. GREENSTEIN, MD  
WILLIAM E. BEAVEN, MD  
RICHARD Y. DALRYMPLE, MD  
RAYMOND M. ATKINS, MD  
SOO YOUNG OH, MD  
PHILIP J. FERRIS, MD  
GUNTHER D. HIRSCH, MD  
ROBERT L. DAMM, MD (*Advisory Member*)  
LAWRENCE W. MALIN, MD  
MOISES FRAIMAN, MD  
RONALD C. LENTHALL, MD  
JOSEPH A. MEAD, JR., MD  
E. RODERICK SHIPLEY, MD  
DANIEL WILFSON, JR., MD  
ROBERT T. ADKINS, MD  
ROBERT W. IRELAND, MD  
GEORGE S. BANNING, JR., MD  
EDWARD O. HUNT, JR., MD  
LEO H. LEY, JR., MD  
NEIL NOVIN, MD  
EUGENE J. RILEY, MD  
EDWARD J. HINMAN, MD (*Advisory Member*)  
H. VINCENT DAVIS, MD  
HAMMOND J. DUGAN, JR., MD  
LAWRENCE L. PACKER, MD  
DONALD C. McANENY (*Advisory Member*)  
GARY GREENHUT (*Advisory Member*)  
JOSEPH I. BERMAN, MD  
THOMAS G. EDISON, MD  
JOSEPH M. SANCHEZ, MD  
LESLIE R. MILES, MD  
CHARLES H. LIGON, MD  
JAY W. McROBERTS, MD  
RAYMOND M. ATKINS, MD  
JAMES A. STERLING, MD  
JUANITO ROA, MD  
GEORGE M. SIMONS, MD  
LEWIS M. BURDETTE, MD  
ROBERT F. SPICER, MD

*Subcommittee on Immunization Projects*

KARL M. GREEN, MD, *Chairman*  
CHESTER C. COLLINS, JR., MD  
ROBERT E. FARBER, MD  
HOWARD J. GARBER, MD (*Advisory Member*)  
MURRAY M. KAPPELMAN, MD  
GEORGE H. MITCHELL, MD  
LAWRENCE C. PAKULA, MD  
JOHN L. PITTS, MD  
MARGARET LEE SHERRARD, MD  
BENJAMIN D. WHITE, MD  
ROBERT E. YIM, MD  
MR. WAYNE BOBBITT (*Advisory Member*)

*Subcommittee on Maternal Welfare*

D. FRANK KALTREIDER, MD, *Chairman*  
J. TYLER BAKER, MD  
GEORGE H. DAVIS, MD  
RAFAEL GARCIA-BUNUEL, MD  
JOHN S. HAUGHT, MD  
MERVYN L. CAREY, MD  
HUGH B. McNALLY, MD  
J. KING B. E. SEEGAR, JR., MD  
HAROLD ROSEN, MD  
EDWIN R. RUZICKA, MD  
JOHN E. SAVAGE, MD  
HERBERT L. YOUSEM, MD

*Subcommittee on Continuing Medical Education*

FRED J. HELDRICH, MD, *Chairman*  
SHERMAN S. ROBINSON, MD  
EDMUND G. BEACHAM, MD  
RONALD R. BERGER, MD  
JOHN A. ENGERS, JR., MD  
GEORGE J. WEEMS, MD  
ROBERT F. BELL, MD  
GEORGE M. SIMONS, MD  
ALBERT NAHAM, MD  
R. LANE WROTH, MD  
CARL J. HOUMANN, MD  
ROBERT J. FURIE, MD (*Advisory Member*)  
THADDEUS E. PROUT, MD  
GUNTHER D. HIRSCH, MD  
SAMUEL P. ASPER, MD  
ARTHUR T. KEEFE, JR., MD  
AUBREY D. RICHARDSON, MD  
RALPH WEBER, MD  
JAMES R. KARNs, MD  
HARRY MCB. BECK, MD  
RICHARD A. YATES, MD (*Advisory Member*)  
WILLIAM SCHUMAN, MD  
PAUL E. HUFFINGTON, JR., MD  
FREDERICK M. JOHNSON, MD  
JAMES D. CARR, MD  
WILLIAM R. NEWMAN, MD  
LEON G. SHEER, MD  
EMIDIO A. BIANCO, MD  
ROBERT E. MAY, MD  
WILLIAM C. MULFORD, MD  
PEITRO U. CAPURRO, MD  
WILSON GRUBB, MD  
DONALD J. ROOP, MD  
WILLIAM L. STEWART, MD  
CHARLES C. SPENCER, MD  
JAMES A. STERLING, MD  
JOHN COLLINS HARVEY, MD

*Subcommittee on Medical Aspects of Sports*

RAMSAY B. THOMAS, MD, *Chairman*  
JAMES W. BANKS, MD  
ROBERT G. BREWER, MD  
CHARLES M. HENDERSON, MD  
G. OVERTON HIMMELWRIGHT, MD  
FRED M. JOHNSON, MD  
CLARENCE E. McWILLIAMS, MD  
HERBERT W. LAPP, MD  
HERMAN C. MAGANZINI, MD  
WILLARD R. PARSON, DDS (*Advisory Member*)  
MR. AL MALONE, Supervisor (*Advisory Member*)  
MR. JOHN MANLEY (*Advisory Member*)  
JOHN H. KAHNERT, PhD (*Advisory Member*)  
MR. ELMON VERNIER (*Advisory Member*)  
JOSEPH ALVAREZ, MD  
JOHN S. GREEN, III, MD  
MR. PAUL RUSKO (*Advisory Member*)  
SHERMAN S. ROBINSON, MD

*Subcommittee on Traffic Safety*

PERRY STEARNS, MD, *Chairman*  
RAYMOND M. ATKINS, MD  
TIMOTHY D. BAKER, MD  
RUTH W. BALDWIN, MD  
RUDIGER BREITENECKER, MD  
GEORGE J. COHEN, MD  
RAYMOND M. CUNNINGHAM, MD  
JOHN E. GESSNER, MD  
IRENE L. HITCHMAN, MD  
PAUL V. JOLIET, MD  
HOWARD F. KINNAMON, MD  
JOHN I. F. KNUD-HANSEN, MD  
ROBERT J. WILDER, MD



## PROFESSIONAL MEDICAL SERVICES COMMITTEE

*Mr. President and Members of the House of Delegates:*

Four meetings of the full Professional Medical Services Committee and two subcommittee meetings were held during the past year. As a result of meeting with representatives of the State Department of Health and Mental Hygiene, a report was prepared which was submitted to the Assistant Secretary of Health and Mental Hygiene for his comment. However, no action was taken on the final report concerning deficiencies in the Medicaid program and suggestions for its improvement, except to distribute it to the Council with the request that it be disseminated to members through the *Journal*, or other means. Recommendations were made to the Department of Health and Mental Hygiene concerning consultant fee schedules.

After repeated discussions of the possible adoption of a Relative Value Scale, and lengthy discussions regarding the need for updated fee figures, a resolution was prepared for presentation to the House of Delegates. This resolution was adopted and charged this committee with establishing valid data concerning current charges for physicians' services, based on usual, customary and reasonable fees charged private patients in Maryland, and with revising such data at intervals not to exceed every three years.

Three subcommittees were subsequently appointed to accomplish these charges; the Subcommittee on Collection and Evaluation of Fee Data, the Subcommittee on Continued Revisions and Updating of Fee Data and the Subcommittee on RVS Adoption. The first two subcommittees have each held one meeting in which

plans were initiated to carry out the charge to the House of Delegates.

Respectfully submitted,

MORRIS J. WIZENBERG, MD, *Chairman*  
THEODORE E. STACY, JR., MD  
WILLIAM KRESS, DDS  
STANLEY N. YAFFEE, MD  
SAMUEL M. M. LUMPKIN, MD  
JOHN FENWICK, MD  
ARTHUR T. HALL, JR., MD  
WORTH B. DANIELS, MD  
STUART N. CHRISTILF, JR., MD  
HARRY G. RANDALL, II, MD  
JOHN E. ADAMS, MD  
ALBERT J. WEISS, MD  
B. STANLEY COHEN, MD  
LEX B. SMITH, MD  
SALVATORE J. DEMARCO, III, MD  
FRANK FARAINO, MD  
ROBERT B. GOLDSTEIN, MD  
P. W. MERCER, MD  
CHARLES EARL HILL, MD  
ANDREW C. MITCHELL, MD  
BENJAMIN S. MILLER, MD  
DONALD W. MINTZER, MD  
WILLIAM A. MOSBERG, JR., MD  
ROBERT W. JOHNSON, III, MD  
ROBERT T. THIBADEAU, MD  
WILLIAM A. TYSON, MD  
EDWIN H. STEWART, JR., MD

## COMMITTEE ON PROGRAMS AND ARRANGEMENTS

*Mr. President and Members of the House of Delegates:*

This committee has met frequently to discuss making certain changes which would enhance the Annual and Semiannual Meeting programs, with the aim of involving more physician members in the scientific continuing education, and social aspects of the Faculty.

For at least four years, the committee has been convinced that the format of the Annual Meeting should be changed. The overall high registration, in contrast to the poor attendance, might be improved if the specialty groups met in conjunction with the Annual Meeting. It is suggested that the endowed lectureships continue as a mechanism to provide prominent speakers for these sessions.

It was recommended that the Subcommittee on Continuing Medical Education be raised to the status of a full committee. With increased emphasis being placed on peer review and periodic recertification, additional offerings in the field of continuing education should be

sponsored by the Faculty. It was suggested and approved that the Committee on Program and Arrangements hold joint meetings with the Subcommittee (or Committee) on Continuing Medical Education to discuss improving the scientific programs for the Annual and Semiannual Meetings, as well as other forms of continuing medical education. A letter to this effect was sent to the Council by the committee chairman.

The Semiannual Meeting, held at the Hotel Hershey for the second year, was well attended. The general registration was higher than in 1969, and the attendance at the scientific sessions was encouraging. The scientific program on Environmental Pollution was very well received, as were the scientific sessions of the specialty societies. Excellent professional entertainment was provided and a most enjoyable theatrical performance was produced by members of the Faculty and Auxiliary.

The highly successful 1971 Annual Meeting, held at the Baltimore Civic Center, also entailed considerable planning. The highest registration ever was recorded at



this session—1,485 registrants, including 833 physicians. The attendance at the individual scientific sessions was considerably higher than in the past few years.

The Health Evaluation Tests were held again this year and more physicians than ever before took advantage of the many tests offered. These tests are a particularly arduous task and consume many, many hours of planning and processing by the subcommittee members.

The technical exhibitors were quite pleased with the new location and, in general, felt that the interest of physicians was greater than at any previous meeting. Because larger facilities were made available, more scientific exhibits were displayed. All were excellent educational additions to the meeting.

The first Art and Hobby Show was held under the auspices of the Woman's Auxiliary, in conjunction with the Annual Meeting. There were 127 items submitted by Faculty members and their families. Prizes, donated by pharmaceutical and medical supply companies, were awarded. Much interest was shown in this unique venture and it is hoped this will be an annual function of the meeting.

For the first time in the history of the Faculty, the 1971 Semiannual Meeting will include out-of-country post-meeting sessions at the El Conquistador Hotel in Puerto Rico. Plans are being made to have speakers from Puerto Rico if possible, many of whom have trained in Maryland. The Semiannual business meetings of the Faculty will be held on Saturday, September 11, at 1211 Cathedral Street in Baltimore.

All in all, it has been a year of change following sober introspection on the status quo of Faculty meetings in general.

A great deal of time was spent by the committee in investigating sites for future meetings. A decision was made to hold the 1972 Annual Meeting at the Hunt Valley Inn in Cockeysville on May 10, 11, and 12.\*

Tentative reservations were also made for the Convention Hall at Ocean City for the 1972 Semiannual

Meeting. This would mark the return of the Medical and Chirurgical Faculty to that ocean resort after four years of meeting elsewhere.

Sincere appreciation is extended to the many members of the Faculty who were responsible for making the 1970 Semiannual and 1971 Annual Meetings so very successful. Our special thanks go to the Auxiliary, the subcommittee members, and the Faculty staff who were so faithful and who devoted so much time.

Finally, we would be remiss if we did not give special thanks to Genevieve Ritchie for her continuing and untiring efforts on behalf of this committee.

\* Later changed because of the high costs involved.

Respectfully submitted,

ARLIE R. MANSBERGER, JR., MD, *Chairman*  
JOHN B. DE HOFF, MD  
WILLIAM L. STEWART, MD  
ALBERT M. ANTLITZ, MD  
MRS. RAYMOND M. YOW  
HARRY W. DRESSLE, DDS

#### *Subcommittee on Exhibits*

JOHN B. DE HOFF, MD, *Chairman*  
WILLIAM L. STEWART, MD  
RICHARD R. CRANE  
GORDON WEHRLE

#### *Subcommittee on Health Evaluation Tests*

VICTOR A. FAZEKAS, MD, *Chairman*  
JAMES E. TAYLOR, MD  
LOUIS H. SCHAFER, MD  
JAMES M. BISANAR, MD  
LEONARD H. BERGER, MD  
ANTOINETTE WOLSKI (ASCP)  
DOROTHY HARTEL

#### *Subcommittee on Art and Hobby Show*

MRS. BERNARD S. GORDON, *Chairman*  
MRS. GEORGE J. BURKE  
MRS. ROBERT W. GARIS  
MRS. DEZSO MERENYI  
MRS. GEORGE H. YEAGER  
MRS. MICHAEL DODD

## PUBLIC RELATIONS COMMITTEE

*Mr. President and Members of the House of Delegates:*

There has been just one meeting of the Public Relations Committee, but that meeting put the wheels in motion for several activities sponsored by the committee.

The committee has adopted the concept that the major focus of public relations by all committees of the Faculty such as Peer Review and Mediation should be to assure the highest quality of care in the community. This is the best public relations job we can do.

Probably the most important and the most far-reaching accomplishment of the year has been the initiation of dialogue between practicing physicians and the deans of the two Maryland medical schools concerning increased enrollment. A resolution, referred to this committee, was studied and returned to Council where it was finally approved. This resolution expressed con-

cern to the two deans for the need for additional enrollment, and suggested means of extending training through the community hospitals. A carefully composed letter was sent to the deans, who immediately responded favorably.

Subsequently, your chairman attended a meeting with the Maryland Congressional Delegation, the two deans of the medical schools, and the dean of the dental school concerning this subject. Great interest was shown, particularly by U.S. Senator Mathias who indicated that he would be very happy to assist by requesting additional funds if necessary. A meeting was held, as well, with representatives of community hospitals on this same subject. Additional support was also indicated from these representatives. Dialogue is continuing.

A highlight of the year was the docking of the SS HOPE in Baltimore. The Woman's Auxiliary, with the



sponsorship of this committee, held a tour of the ship and a buffet dinner-party at Martin's West. It is hoped that if another such celebration is planned, physician attendance will be greater. Support of those who did attend and who contributed is appreciated.

Medical assistants' seminars are continuing; three were held during the year and all were very successful in terms of attendance. The Public Speakers Training Program was also held and enthusiasm was such that another will be planned soon. Gift subscriptions of *Today's Health* to Maryland universities and colleges will be continued as a project of this committee. Con-

tinuing attention will be given to the possibility of permanent, part-time public relations personnel, as the need increases.

Respectfully submitted,

PAUL A. MULLAN, MD, *Chairman*  
ANNIE M. BESTEBREURTJE, MD  
LIONEL A. DESBORDES, MD  
RAYMOND J. DONOVAN, Jr., MD  
WILLIAM DUNSEATH, MD  
GUNTHER D. HIRSCH, MD  
LEEDS E. KATZEN, MD  
SOL B. LOVE, DDS  
MRS. H. LEONARD WARRES

## REFERENCE COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Reference Committee met on Thursday, April 15, 1971 to consider the three resolutions which had been submitted. All Faculty members had been notified of the resolutions to be considered and the meeting date. Those interested members of the Faculty attended, and the sponsors of the resolutions sent a representative.

As is the custom, the House of Delegates will act on the resolutions themselves, and not on the Reference Committee's recommendations.

### *Resolution 1A/71*

Whereas, In 1962, as a result of a Professional Management Study, the Faculty considered the question of hiring a Professional Negotiator; and

Whereas, Many convincing arguments were presented at that time for the Faculty to take such action, including:

- a) Negotiation is a highly skilled art requiring special knowledge and training.
- b) The Government and other parties are always represented by a Professional Negotiator.
- c) Medical and Chirurgical Faculty in the past, has been represented by committees of physicians who, by and large, are untrained in negotiating skills.
- d) The committees change from time-to-time preventing any real continuity on a year-to-year basis.
- e) It will provide a consensus for the profession, whereas decisions are sometimes not reached for the benefit of the majority.
- f) Such a negotiator would know the appropriate time to reach a compromise in the best interests of the public.
- g) Continued contact with persons "on the other side" would make negotiation easier and more constructive; and

Whereas, These arguments are still valid and, perhaps more so, because of the increasing number of prepayment mechanisms that are coming into play; therefore, be it

Resolved, That the Council of the Medical and Chirurgical Faculty of the State of Maryland be directed to seek out and employ a qualified negotiator, in whose charge would be placed the responsibility for dealing with third party payment mechanisms under the policy direction of

an appropriate committee; and be it further

Resolved, That the duties and responsibilities of such an individual include other related socioeconomic matters deemed appropriate by the Council.

Since legal counsel advises that employment of a negotiator may raise some questions in the anti-trust area and, further, since employment of a negotiator would appear to be in conflict with Medical and Chirurgical Faculty position advocating Usual and Customary fees, it is recommended that this resolution be referred to the Policy and Planning Committee.

### *Resolution 2A/71*

Whereas, There is an increasingly well documented need for controlling medical care costs, conserving hospital and skilled nursing home resources and making optimum use of scarce, highly trained medical manpower; and

Whereas, Many patients now cared for in hospitals or skilled nursing homes could receive less expensive, more appropriate care in their own homes through a well planned, well administered home care service; and

Whereas, In Maryland there is inadequate private and governmental financing to encourage development of such comprehensive home care service; therefore, be it Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urges the formation of home health care services programs for the residents of Maryland; and

Resolved, That since many Blue Cross plans throughout the country now offer home care services coverage to their subscribers, the Medical and Chirurgical Faculty of the State of Maryland requests that Maryland Hospital Services, Inc., work with the medical and related professions to formulate plans for home care services for its subscribers; and

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland TAKE ANY NECESSARY ACTION TO (request local, state, and federal legislators to hold open hearings in Maryland to investigate the needs for home health care and) find methods for INITIATING AND financing such a program under Medicaid and Medicare.

( ) indicates deletions  
CAPS indicates additions



The Reference Committee approves the concept of this resolution, as amended, to which amendments the sponsors have agreed, and recommends its adoption inasmuch as Blue Cross and other groups are currently working on such a program.

#### *Resolution 3A/71*

Whereas, There remains a critical shortage of family physicians in the State of Maryland; and

Whereas, It was hoped to relieve this shortage, at least in part, by developing a training program in Family Practice at the University of Maryland School of Medicine; and

Whereas, This program which has now been functioning for FOUR years has already made significant strides in its goals of interesting students in Family Practice and training interns and residents in Family Practice; and

Whereas, This program (is now) HAS BEEN in (serious) danger of foundering due to (lack of) INADEQUACY OF support from the administration of the Medical School, particularly (lack of) INADEQUATE funding and (lack) INADEQUACY of space; therefore, be it

**Resolved, That the House of Delegates communicate its immediate concern to the Dean of the University of Maryland School of Medicine for (his) THE failure OF COMMITMENT to support the Family Practice Program; and**

**Resolved, That the House of Delegates (instruct the Legislative Committee to) prevail upon the UNIVERSITY OF MARYLAND AND ITS SCHOOL OF MEDICINE (General Assembly and Board of Regents) to establish a separate Department of Family Practice at the School of Medicine on equal par with the other major departments, in place of the present Division of Family Medicine which is under the Department of Medicine, and that this SEPARATE Department be funded in a more realistic manner in relation to its needs.**

The Reference Committee heard testimony from representatives of the University of Maryland School of Medicine as well as the Maryland Academy of General Practice and from those who participate in this teaching program at the University of Maryland School of Medicine.

A number of changes were made in this resolution and all were accepted by Vincent Fiocco, MD, representing the Carroll County Medical Society, the resolution's sponsor.

The committee recommends passage of this resolution in the hope it will assist the University of Maryland in establishing a strong family practice program.

Respectfully submitted,

HERBERT H. LEIGHTON, MD, *Chairman*  
MELVIN B. DAVIS, MD  
MARVIN I. MONES, MD  
WILLIAM H. MOSBERG, JR., MD  
RAYMOND M. YOW, MD

## **SPECIAL COMMITTEES**

### **Ad Hoc Liaison Committee with AFL/CIO Representatives**

*Mr. President and Members of the House of Delegates:*

This Ad Hoc Liaison Committee was named in response to a request from representatives of the local AFL/CIO units. This request was made because many of those in the labor movement alleged that they had difficulty in obtaining the services of a family physician who they could see on a regular basis. They also alleged that physicians were not available outside normal working hours to see patients either for routine illnesses or for emergencies. Allegations were also made that costs under the present system for delivery of health services are continually rising and that a reorganization of health care delivery might stem such a continuing increase in costs.

Two meetings of the full committee have been held. In addition, two informal discussion sessions were held with staff representatives on hand.

At the present time, there is nothing to report as a result of this committee's activity. It is also extremely unlikely that anything will come from its actions inasmuch as the last meeting on September 17, 1970 closed with the statement that AFL/CIO representatives would get in touch with the Faculty to set up any future meeting date.

Respectfully submitted,

JOHN F. SCHAEFER, MD  
CHARLES F. O'DONNELL, MD  
LEWIS P. GUNDY, MD  
MORRIS J. WIZENBERG, MD  
ROBERT J. THOMAS, MD  
CHARLES W. KINZER, MD

### **Ad Hoc Committee on New Faculty Building**

*Mr. President and Members of the House of Delegates:*

This committee has had two meetings since its formation. Discussions are now under way with representatives of the Sheppard-Pratt Hospital toward arranging for use of the land in that area of the state.

As of this date, no concrete arrangements have been made. These are, of necessity, the prerogatives of the House of Delegates. It is anticipated that much more study must take place before any such recommendations can be developed.

Respectfully submitted,

RUSSELL S. FISHER, MD, *Chairman*  
M. MCKENDREE BOYER, MD  
HENRY A. BRIELE, MD  
A. C. DICK, JR., MD  
PAUL F. GUERIN, MD  
JAMES R. KARNS, MD



# ANNUAL FINANCIAL STATEMENT

## of the

### Medical and Chirurgical Faculty

### of the State of Maryland

March 18, 1971

#### CERTIFICATE

The Medical and Chirurgical Faculty  
of The State of Maryland,  
1211 Cathedral Street,  
Baltimore, Maryland 21201

Gentlemen:

We have made an audit of the records of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31, 1970. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the balance sheet, together with the supporting statements, present fairly the financial position of the Faculty as of December 31, 1970 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

WOODEN & BENSON





# THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND Baltimore, Maryland

EXHIBIT A

## BALANCE SHEET—DECEMBER 31, 1970

ASSETS		LIABILITIES AND CAPITAL	
GENERAL FUND			
<i>Cash</i>		<i>Liabilities</i>	
Maryland National Bank		Accounts Payable	
Regular checking .....	204,644.59	Trade .....	1,084.58
Payroll .....	6,946.10	American Medical Association—dues collected ..	82,675.00
Savings account .....	15,723.15	Plant Fund .....	6,085.00
Petty cash funds .....	400.00	Component Societies—dues collected .....	34,866.00
	227,713.84		124,710.58
<i>Accounts Receivable</i>			
Membership dues, journal subscriptions, etc. ....	14,780.10		
Due from Other Funds			
Consolidated Fund .....	23,832.42	Payroll Taxes	
Harvey G. Beck—Lectureship Fund .....	160.00	Withholding	
Jesse C. Coggins—Lectureship Fund .....	247.50	Federal .....	567.34
Med-Chi Insurance Trust Fund ...	930.84	State .....	816.47
Steiner Fund .....	8,222.07	Old age benefit .....	959.40
Educational Fund .....	14,030.56	Unemployment Insurance	
	47,423.39	Federal .....	332.39
		State .....	20.31
			2,695.91
<i>Loan Receivable</i>			
Plant Fund .....		Accrued Expenses—Insurance .....	85.00
Deferred Charges		Designated Fund—Library Account—books and journals .....	2,830.56
Air travel .....	425.00	Deferred Income—1970 Dues .....	72,755.00
Insurance premiums .....	1,582.36	Surplus—Exhibit C .....	118,847.64
			321,924.69
Total General Fund Assets .....	321,924.69		321,924.69
		ENDOWMENT AND OTHER SPECIAL FUNDS	
Consolidated Fund—Exhibit A-1 .....	303,619.33	Consolidated Fund—Exhibit A-1 .....	303,619.33
Funded Reserve—Exhibit A-2 .....	19,675.33	Funded Reserve—Exhibit A-2 .....	19,675.33
Harvey G. Beck—Lectureship Fund—Exhibit A-3 .....	3,524.71	Harvey G. Beck—Lectureship Fund—Exhibit A-3 .....	3,524.71
Jesse C. Coggins—Lectureship—		Jesse C. Coggins	
Cash—Maryland National Bank .....	5,606.08	Lectureship—Due General Fund ....	247.50
New Building Fund—Exhibit A-4 .....	198,160.43	—Capital—Exhibit J ....	5,358.58
			5,606.08
George M. Boyer—Lectureship Fund		New Building Fund—Exhibit A-4 .....	198,160.43
Cash—Loyola Federal Savings and Loan Association .....	5,590.06	George M. Boyer—Lectureship Fund—Capital .....	5,590.06
Amos Koontz—Memorial Fund—Exhibit A-5 .....	2,703.07	Amos Koontz—Memorial Fund—Exhibit A-5 .....	2,703.07
Educational Fund—Exhibit A-6 .....	47,139.77	Educational Fund—Exhibit A-6 .....	47,139.77



Medical Annals Fund			
Cash—National City Bank	1,431.53	Medical Annals Fund—Capital—Exhibit M	1,431.53
Henry P. Laughlin—Special Award Fund			
Cash—Loyola Federal Savings and Loan Association	3,591.46	Henry F. Laughlin—Special Award Fund—Capital	3,591.46
J. Mason Hundley Memorial Fund			
Cash—Loyola Federal Savings and Loan Association	6,486.65	J. Mason Hundley—Memorial Fund—Capital	6,486.65
Lewis H. Steiner Fund—Exhibit A-7	414,577.88	Lewis H. Steiner Fund—Exhibit A-7	414,577.88
Community Health Project Fund			
Cash—Loyola Federal Savings and Loan Association	5,995.05	Community Health Project Fund—Capital	5,995.05
Total Endowment and Other Special Funds—Assets	<u>1,018,101.35</u>	Total Endowment and Other Special Funds—Liabilities and Capital	<u>1,018,101.35</u>

PLANT FUND

Cash—Maryland National Bank	35,144.69	<i>Liabilities</i>	
Accounts Receivable—General Fund	6,085.00	Jesse C. Coggins—New Building Fund	
Fixed Assets—(No Depreciation Provided)		Principal account	44,283.02
1215-1217 Cathedral Street—land—cost	19,118.95	Income account	750.00
1209-1215 Cathedral Street		Loan payable—General Fund	30,000.00
Land—building—cost	110,635.76		<u>75,033.02</u>
Improvements—cost	331,525.47		
*Personal Property			
Library books—journals	231,370.00	Capital—Exhibit O	801,196.33
Office, library, fixtures, antiques	77,349.48		<u>876,229.35</u>
and museum pieces	65,000.00		
Portraits	373,719.48		
	<u>834,999.66</u>		
	<u>876,229.35</u>		

MED-CHI INSURANCE TRUST FUND

Investments—short term—redeemed and deposited in Maryland National Bank—checking account February 4, 1971 (covering overdraft)	39,327.50	<i>Liabilities</i>	
Prepaid Insurance Premiums	475.00	Maryland National Bank—overdraft	1,037.96
		Subscriber overpayments	105.50
		Edward H. Friend and Company—Consulting Actuaries	337.50
		Due General Fund for expenditures	930.84
		Others	1,931.88
			<u>4,343.68</u>
		Capital—Exhibit P	35,458.82
Total Med-Chi Insurance Trust Fund Assets	<u>39,802.50</u>	Total Med-Chi Insurance Trust Fund—Liabilities and Capital	<u>39,802.50</u>
Grand Total—All Funds	<u>2,256,057.89</u>	Grand Total—All Funds	<u>2,256,057.89</u>

\* The appraised value of portraits as of December 31, 1963 was \$65,000, an increase of \$51,000 over prior years. All other personal property appraised as of December 31, 1949, with subsequent additions at cost.



# STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For Year Ended December 31, 1970

EXHIBIT B

## GENERAL FUND

### Income

Dues—Baltimore City Dental Society .....	1,840.00	
—Baltimore City Medical Society .....	107,820.00	
—County Medical Society .....	140,208.00	249,868.00
Rents and Services		
Baltimore City Medical Society .....	26,000.00	
Others .....	8,090.00	34,090.00
Meetings—Annual and Semi-Annual Exhibits .....		19,752.10
Journal—Advertising .....	61,337.06	
—Subscriptions .....	2,464.34	63,801.40
Addressograph service .....		1,153.79
Interest on savings accounts .....		13,242.10
Miscellaneous .....		2,179.64
		384,087.03
Transfers from Consolidated Fund—Income for General purposes—Exhibit F .....		5,066.65
Total Income and Transfers—Forwarded .....		389,153.68

### Expenses

Accounting Fees .....	2,290.15	
Communication—postage, telephone and telegraph .....	12,370.83	
Contributions .....	900.00	
Equipment rental and maintenance .....	4,050.34	
Fuel .....	1,532.76	
Gas, electricity and water .....	5,344.49	
Household and janitorial services .....	1,949.14	
Insurance—general .....	2,284.25	
—hospitalization .....	3,448.80	
Journal expenses—printing and commissions .....	93,262.84	
Legal fees .....	11,117.26	
Legislature .....	5,741.71	
Property maintenance .....	2,379.03	
Meetings—annual and semi-annual .....	29,340.78	
Office supplies .....	3,228.44	
Purchases of equipment .....	747.80	
Pension and major medical contribution .....	14,729.71	
Printing .....	4,947.49	
Salaries .....	174,695.05	
Social Security .....	7,546.61	
Unemployment insurance—Federal .....	440.94	
—State .....	264.56	
Travel .....	6,666.61	
Supplementary hours .....	2,239.70	
Library .....	3,662.14	
Miscellaneous .....	4,711.26	
Women's Auxiliary .....	1,000.00	
Total Expenses .....		400,892.69
Excess of Expenses over Income and Transfers—To Exhibit C .....		11,739.01



## STATEMENT OF SURPLUS

For Year Ended December 31, 1970

## GENERAL FUND

January 1, 1970—Balance .....	130,586.65
<i>Deduction</i>	
Excess of Expenses over Income and Transfers for the year ended December 31, 1970—Exhibit B .....	11,739.01
	<hr/>
December 31, 1970—Balance to Exhibit A .....	118,847.64
	<hr/>

EXHIBIT A-1

## BALANCE SHEET—DECEMBER 31, 1970

## CONSOLIDATED FUND

## ASSETS

*Income Account*

Cash—The Savings Bank of Baltimore—Exhibit F			
Eugene Cordell Fund .....	13,023.42		
Special Account .....	35,504.47	48,527.89	
	<hr/>		
Dividends receivable .....		2,160.59	
<i>Investments</i>			
Eugene Cordell Fund—Held by Maryland National Bank—Agent—Exhibit F			
Cash .....	274.70		
Common stocks .....	8,679.54	8,954.24	59,642.72
	<hr/>	<hr/>	

*Principal Account*

Held by Maryland National Bank—Agent			
Cash .....		1,189.74	
Investments—at cost (Total from Exhibit G)			
Bonds			
United States Government and Municipals .....	3,578.75		
Others .....	108,470.55	112,049.30	
	<hr/>		
Stocks .....		130,737.57	243,976.61
		<hr/>	

Total—Income and Principal Accounts Assets—To Exhibit A .....			303,619.33
			<hr/>

## LIABILITIES AND CAPITAL

*Income Account**Liabilities*

Due—General Fund .....	22,011.95		
—Eugene Fauntleroy Cordell Fund .....	987.02		
	<hr/>		
Total—Exhibit F .....		22,998.97	
Capital—Exhibit E .....		36,643.75	59,642.72
		<hr/>	

*Principal Account*

Capital—Exhibit G .....			243,976.61
			<hr/>

Total—Income and Principal Accounts Liabilities and Capital—To Exhibit A .....			303,619.33
			<hr/>



## BALANCE SHEET—DECEMBER 31, 1970

## FUNDED RESERVE

ASSETS		
<i>Income Account</i>		
Cash—Savings Bank of Baltimore .....	5,025.90	
Due from principal account—contra .....	480.34	5,506.24
<i>Principal Account</i>		
Investments—Held by Maryland National Bank—Agent		
Cash .....	735.61	
Common stock .....	13,433.48	14,169.09
Total—Income and Principal Account—Assets—To Exhibit A .....		<u>19,675.33</u>
LIABILITIES AND CAPITAL		
<i>Income Account</i>		
Capital—Exhibit H .....		5,506.24
<i>Principal Account</i>		
Liability		
Due—income account—contra .....	480.34	
Capital—Exhibit H .....	13,688.75	14,169.09
Total—Income and Principal Accounts—Liabilities and Capital—To Exhibit A .....		<u>19,675.33</u>

## BALANCE SHEET—DECEMBER 31, 1970

## HARVEY G. BECK—LECTURESHIP FUND

ASSETS		
<i>Income Account</i>		
Cash—Savings Bank of Baltimore .....		1,391.80
<i>Principal Account</i>		
Investments—Held by Maryland National Bank—Agent		
Cash .....	163.17	
Common stock .....	1,969.74	2,132.91
Total—Income and Principal Accounts—Assets—To Exhibit A .....		<u>3,524.71</u>
LIABILITIES AND CAPITAL		
<i>Income Account</i>		
Liabilities		
Due to General Fund .....		160.00
Capital—Exhibit I .....		1,231.80
		<u>1,391.80</u>
<i>Principal Account</i>		
Capital—Exhibit I .....		2,132.91
Total—Income and Principal Accounts—Liabilities and Capital—To Exhibit A .....		<u>3,524.71</u>



**BALANCE SHEET—DECEMBER 31, 1970**  
**JESSE C. COGGINS—NEW BUILDING FUND**

## ASSETS

*Income Account*

Cash—Loyola Federal Savings and Loan Association .....	31,398.75	
—Maryland National Bank .....	791.74	32,190.49
Accrued interest on loan to plant fund .....	750.00	
Investments—at cost .....	63,219.94	96,160.43

*Principal Account*

Accounts Receivable		
Due from plant fund .....	44,283.02	
Due from income account—contra .....	57,716.98	102,000.00

Total—Income and Principal Accounts—Assets—To Exhibit A ..... 198,160.43

## LIABILITIES AND CAPITAL

*Income Account*

Liabilities		
Due to principal account—contra .....	57,716.98	
Capital (includes \$2,551.87 of interest and dividends earned during year).....	38,443.45	96,160.43

*Principal Account*

Capital .....		102,000.00
---------------	--	------------

Total—Income and Principal Accounts—Liabilities and Capital—  
 To Exhibit A ..... 198,160.43

**BALANCE SHEET—DECEMBER 31, 1970**  
**AMOS KOONTZ—MEMORIAL FUND**

## ASSETS

*Principal Account*

Cash—Loyola Federal Savings and Loan Association .....	2,703.07
--	----------

Total—Principal Account—Assets—To Exhibit A ..... 2,703.07

## LIABILITIES AND CAPITAL

*Principal Account*

Liabilities .....	None
Capital—Exhibit K .....	2,703.07

Total—Principal Account—Liabilities and Capital—To Exhibit A ..... 2,703.07

**BALANCE SHEET—DECEMBER 31, 1970**  
**EDUCATIONAL FUND**

## ASSETS

*Principal Account*

Cash—Maryland National Bank—Savings Account .....	47,139.77
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Total—Principal Account—Assets—To Exhibit A ..... 47,139.77

## LIABILITIES AND CAPITAL

*Principal Account*

Liabilities	
Due to General Fund for expenditures .....	14,030.56
Capital—Exhibit L .....	33,109.21

Total—Principal Account—Liabilities and Capital—To Exhibit A ..... 47,139.77



**BALANCE SHEET—DECEMBER 31, 1970**  
**LEWIS H. STEINER FUND**

**ASSETS**

<i>Income Account</i>	
Cash—Savings Bank of Baltimore .....	38,607.23
Dividend receivable .....	722.06
	<hr/>
Total Income Account—Assets .....	39,329.29
<i>Principal Account</i>	
Uninvested cash—Maryland National Bank .....	1,315.57
Due from—income account—contra .....	5,160.41
Investments—at book value .....	368,772.61
	<hr/>
Total Principal Account—Assets .....	375,248.59
Grand Total—Income and Principal Accounts—Assets—To Exhibit A .....	414,577.88
	<hr/> <hr/>

**LIABILITIES AND CAPITAL**

<i>Income Accounts</i>	
Liabilities	
Due to—General Fund for expenditures .....	8,222.07
—principal account—contra .....	5,160.41
	<hr/>
Capital—Exhibit N .....	25,946.81
	<hr/>
Total Income Account—Liabilities and Capital .....	39,329.29
<i>Principal Account</i>	
Capital—Exhibit N .....	375,248.59
	<hr/>
Grand Total—Income and Principal Accounts—Liabilities and Capital—To Exhibit A .....	414,577.88
	<hr/> <hr/>

EXHIBIT D

**STATEMENT OF INCOME, EXPENSES AND APPROPRIATIONS**  
**For Year Ended December 31, 1970**

**CONSOLIDATED FUND—INCOME ACCOUNT**

<i>Income</i>	
Investments—General	
Bonds	
United States Government and Municipal .....	716.00
Others .....	13,458.18
	<hr/>
Stocks	
Preferred .....	716.00
Common .....	13,458.18
	<hr/>
Interest on Special Savings Accounts—The Savings Bank of Baltimore .....	1,314.41
	<hr/>
Less—agency fees .....	634.91
—brokers fees .....	1,639.61
	<hr/>
Net Income—Exhibit F .....	17,861.98
Investments—Eugene F. Cordell	
Fund—Schedule F	
Stocks	
Common .....	307.20
Less—Agency Fee .....	18.43
	<hr/>
Interest on Savings Account—The Savings Bank of Baltimore—Exhibit F .....	587.97
	<hr/>
	18,738.72
<i>Expenses and Appropriations—Exhibit F</i>	
Library Purposes—General .....	13,714.97
Library Payroll, maintenance, etc. transferred to General Fund .....	5,066.65
Lectureship .....	498.35
Cordell Fund .....	2,400.00
	<hr/>
Excess of Expenses and Appropriations over Income—To Exhibit E .....	2,941.25
	<hr/> <hr/>

EXHIBIT E

**STATEMENT OF CAPITAL**  
**For Year Ended December 31, 1970**

**CONSOLIDATED FUND—INCOME ACCOUNT**

January 1, 1970—Balance—Exhibit F .....	39,585.00
<i>Deduction</i>	
Excess of Expenses and Appropriation over Income for year ended December 31, 1970—Exhibit D .....	2,941.25
	<hr/>
December 31, 1970—Balance—To Exhibits A-1 and F .....	36,643.75
	<hr/> <hr/>



## STATEMENT OF RECEIPTS, EXPENSES AND BALANCES

EXHIBIT F

For Year Ended December 31, 1970

## CONSOLIDATED FUND—INCOME ACCOUNT

Fund	Distributive Share (Percent)	Balance January 1, 1970	Income Received During Year			Balance January 1, 1970 Plus Receipts	Expenses				Balance December 31, 1970	
			Savings Account Interest	Investment Income			Library	Transferred to General Fund (Exhibit B)	Lectureship	Other	Cash Investments and Dividends Receivable	Cash on Deposit
				Distributive Share	Direct							
Baker .....	.65	128.51		101.23		229.74	—				229.74	
Barker, Lewellyn F. ....	.39	93.94		60.74		154.68	—				154.68	
Bowen, Josiah S. ....	9.17	—		1,428.12		1,428.12					—	
Bressler, Frank C. ....	1.80	—		280.33	288.77	280.33					—	
Cordell, Eugene Fauntleroy .	3.64	20,237.44	587.97	566.89		21,681.07					19,281.07	13,023.42
Cowles, Nellie N. ....	.75	1,174.33		116.80		1,291.13	147.92				1,143.21	
Ellis, Charles M. ....	—	—		2,287.50		2,287.50					—	
Finney, John M. T. ....	8.40	5,649.45		1,308.20		6,957.65	584.38				6,078.32	
Frick, William F. ....	15.02	—		2,339.87		2,339.87	2,639.20		294.95		(299.33)	
Friedenwald, Julius F. ....	.75	—		116.80		116.80					—	
Harlan, Herbert .....	.76	344.64		118.36		463.00	232.05				230.95	
McCleary, Standish .....	.75	63.95		116.80		180.75	—				180.75	
Osler Endowment .....	1.40	604.94		218.03		822.97					822.97	
Osler Testimonial .....	7.75	4,021.28		1,206.97		5,228.25	603.49				4,624.76	
Ruhrach, John .....	40.79	1,689.95		6,352.55		8,042.50	9,436.14				(1,393.64)	
Stokes, William Royal .....	3.09	1,305.22		481.23		1,786.45	675.28				1,111.17	
Trimble, Isaac Ridgeway .....	2.64	4,271.35		411.15		4,682.50			203.40		4,479.10	
Woods, Hiram .....	2.25	—		350.41		350.41	350.41				—	
	100.00	*39,585.00	587.97	17,861.98	288.77	58,323.72	13,714.97	498.35	2,400.00		36,643.75	13,023.42
			* To Exhibit E			..... Totals to Exhibit D ..			..... Totals to Exhibit D ..			To Exhibit E
												To Exhibit E

## SUMMARY—To Exhibit A-1

Cash	
Individual Accounts—above .....	13,023.42
Special Accounts .....	35,504.47
Dividends Receivable .....	2,160.59
50,688.48	
Cordell Fund	
Cash .....	274.70
Investments .....	8,679.54
8,954.24	
59,642.72	
Less—Accounts payable to Other Funds .....	22,998.97
36,643.75	



**STATEMENT OF CAPITAL**  
**For Year Ended December 31, 1970**  
**CONSOLIDATED FUND—PRINCIPAL ACCOUNT**

<i>Fund</i>	<i>Purpose</i>	<i>Balance January 1, 1970</i>	<i>Net Profit on Security Sales</i>	<i>Balance December 31, 1970</i>
Baker .....	Book of Materia Medica .....	1,535.12	.16	1,535.28
Barker, Lewellyn F. ....	Library .....	921.08	.10	921.18
Bowen, Josiah S. ....	General .....	21,615.52	2.25	21,617.77
Bressler, Frank C. ....	General .....	4,242.18	.45	4,242.63
Cordell, Eugene Fauntleroy .	Relief of Widows and Orphans .....	8,580.87	.89	8,581.76
Cowles, Nellie N. ....	Books for Neurology .....	1,769.33	.18	1,769.51
Ellis, Charles M. ....	General .....	8,258.46	—	8,258.46
Finney, John M. T. ....	Books, Journals and Lectureship of Surgery .	19,789.94	2.06	19,792.00
Frick, William F. ....	Maintenance of Frick Library and purchase of books and journals .....	35,394.53	3.68	35,398.21
Friedenwald, Dr. Julius ....	Maintenance of Friedenwald Room .....	1,769.34	.18	1,769.52
Harlan, Herbert .....	Books on Ophthalmology .....	1,794.80	.18	1,794.98
McCleary, Standish .....	Lectureship and Books on Pathology .....	1,769.34	.18	1,769.52
Osler Endowment .....	Permanent Endowment for Library by Request of Dr. Osler .....	3,294.93	.34	3,295.27
Osler Testimonial .....	Medical Books and Maintenance of Osler Hall	18,260.94	1.90	18,262.84
Ruhrah, John .....	Library Books, Journals, etc. ....	96,130.29	10.00	96,140.29
Stokes, William Royal .....	Lectureships and Books on Bacteriology or Pathology .....	7,289.19	.76	7,289.95
Trimble, Isaac Ridgeway ...	Lectureship only .....	6,224.94	.65	6,225.59
Woods, Hiram .....	General .....	5,311.30	.55	5,311.85
		<u>243,952.10</u>	<u>24.51</u>	<u>243,976.61</u>
			Total From Schedule G-1	To Exhibit A-1

EXHIBIT G-1

**STATEMENT OF SECURITIES SOLD**  
**During the Year Ended December 31, 1970**  
**CONSOLIDATED FUND—PRINCIPAL ACCOUNT**

<i>Par Value Shares or Rights</i>	<i>Description Bonds</i>	<i>Amount Received</i>	<i>Cost</i>	<i>Profit or (Loss)</i>
15,000	Southland Corporation Convertible Debenture—5½ %— Due March 15, 1989 .....	15,711.55	16,575.00	(863.45)
	<i>Common Stock</i>			
266	Maryland Cup Corporation .....	9,881.49	9,326.53	554.96
102	Dow Chemical .....	6,314.65	6,170.13	144.52
80	E. I. duPont de Nemours .....	9,541.86	13,622.30	(4,080.44)
325	McDonalds Corporation .....	12,403.28	8,815.63	3,587.65
	<i>Stock Rights</i>			
648	American Telephone and Telegraph .....	425.25	—	425.25
460	Standard Oil of New Jersey .....	165.31	—	165.31
90	Xerox Corporation .....	37.97	—	37.97
	<i>Fractional Shares</i>			
770/1,000	Maryland Cup Corporation .....	36.57	—	36.57
849/1,000	Utah Mining and Construction Co. ....	43.51	27.34	16.17
		<u>54,561.44</u>	<u>54,536.93</u>	<u>*24.51</u>

\* To Exhibit  
G



## STATEMENT OF CAPITAL

For Year Ended December 31, 1970

## FUNDED RESERVE

## INCOME ACCOUNT

January 1, 1970—Balance .....		4,549.15
<i>Additions</i>		
Dividends .....	790.70	
Interest—savings account .....	213.84	1,004.54
		<hr/>
		5,553.69
<i>Deductions</i>		
Agency fee .....		47.45
		<hr/>
December 31, 1970—Balance—To Exhibit A-2 .....		<u>5,506.24</u>

## PRINCIPAL ACCOUNT

January 1, 1970—Balance .....		12,861.20
<i>Addition</i>		
Gain on sale of securities:		
75 shares McDonald Corporation		
Received: .....	2,861.92	
Cost .....	2,034.37	
		<hr/>
Gain on Sale .....		827.55
December 31, 1970—Balance—To Exhibit A-2 .....		<u>13,688.75</u>

## STATEMENT OF CAPITAL

For Year Ended December 31, 1970

## HARVEY G. BECK—LECTURESHIP FUND

## INCOME ACCOUNT

January 1, 1970—Balance .....		1,132.23
<i>Additions</i>		
Dividends .....	213.20	
Interest—savings account .....	59.17	272.37
		<hr/>
		1,404.60
<i>Deductions</i>		
Agency fee .....	12.80	
Reimbursement to General Fund for expenditures .....	160.00	172.80
		<hr/>
December 31, 1970—Balance—To Exhibit A-3 .....		<u>1,231.80</u>

## PRINCIPAL ACCOUNT

January 1, 1970—Balance .....		2,079.10
Gain on sale of 82 American Telephone and Telegraph stock rights .....		53.81
		<hr/>
December 31, 1970—Balance—To Exhibit A-3 .....		<u>2,132.91</u>



**STATEMENT OF CAPITAL**  
**For Year Ended December 31, 1970**  
**JESSE C. COGGINS—LECTURESHIP FUND**

January 1, 1970—Balance .....	5,353.28
<i>Addition</i>	
Interest—savings accounts .....	252.80
	<hr/> 5,606.08
<i>Deduction</i>	
Reimbursement to General Fund for expenditures .....	247.50
	<hr/> 5,358.58
December 31, 1970—Balance—To Exhibit A .....	

**STATEMENT OF CAPITAL**  
**For Year Ended December 31, 1970**  
**AMOS KOONTZ—MEMORIAL FUND**

PRINCIPAL ACCOUNT

January 1, 1970—Balance .....	2,772.73
<i>Addition</i>	
Interest on savings account .....	141.19
	<hr/> 2,913.92
<i>Deduction</i>	
Reimbursement to General Fund for expenditures .....	210.85
	<hr/> 2,703.07
December 31, 1970—Balance—To Exhibit A-5 .....	

**STATEMENT OF CAPITAL**  
**For Year Ended December 31, 1970**  
**EDUCATIONAL FUND**

PRINCIPAL ACCOUNT

January 1, 1970—Balance .....		44,941.08
<i>Additions</i>		
Investment income .....	2,198.69	
Income in excess of expenses on ticket sales for Aspect of Sports Seminar .....	322.28	2,520.97
		<hr/> 47,462.05
<i>Deductions</i>		
Medic network .....	8,505.35	
Educational expense .....	5,847.49	14,352.84
		<hr/> 33,109.21
December 31, 1970—Balance—To Exhibit A-6 .....		

**STATEMENT OF CAPITAL**  
**For Year Ended December 31, 1970**  
**MEDICAL ANNALS FUND**

January 1, 1970—Balance .....	1,371.49
<i>Addition</i>	
Interest on savings account .....	60.04
	<hr/> 1,431.53
December 31, 1970—Balance—To Exhibit A .....	



**STATEMENT OF CAPITAL  
For Year Ended December 31, 1970**

**LEWIS H. STEINER FUND**

EXHIBIT N

INCOME ACCOUNT

January 1, 1970—Balance .....		20,888.20
<i>Additions</i>		
Investment income .....	12,336.11	
Interest on savings account .....	1,521.06	13,857.17
		<u>34,745.37</u>
<i>Deductions</i>		
Agency fees .....	618.22	
Reimbursement of General Fund for purchase of library books .....	8,180.34	8,798.56
		<u>8,798.56</u>
December 31, 1970—Balance—To Exhibit A-7 .....		<u>25,946.81</u>

PRINCIPAL ACCOUNT

January 1, 1970—Balance .....		377,400.14
<i>Additions</i>		
Gain on sale of stock rights .....		88.59
		<u>88.59</u>
		377,488.73
<i>Deductions</i>		
Loss on sale of securities .....		2,240.14
		<u>2,240.14</u>
December 31, 1970—Balance—To Exhibit A-7 .....		<u>375,248.59</u>

**STATEMENT OF CAPITAL  
For Year Ended December 31, 1970**

**PLANT FUND**

EXHIBIT O

January 1, 1970—Balance .....		786,476.33
<i>Addition</i>		
Assessments .....		14,720.00
		<u>14,720.00</u>
December 31, 1970—Balance—To Exhibit A .....		<u>801,196.33</u>

**STATEMENT OF CAPITAL  
For Year Ended December 31, 1970  
MED-CHI INSURANCE TRUST FUND**

EXHIBIT P

January 1, 1970—Balance .....			16,194.77
<i>Additions</i>			
Receipts			
Membership Premiums Collected			
Accident, sickness and total disability, etc. ....	306,596.92		
Blue Cross and Blue Shield .....	507,174.16		
Business overhead and disability .....	47,976.72	861,747.80	
		<u>861,747.80</u>	
Retirement program .....		2,026.00	
Administration fees .....		23,508.95	
Interest on securities .....		8,512.87	
		<u>895,795.62</u>	
Disbursements			
Premiums to various insurance companies .....	860,405.74		
Reimbursements to subscribers .....	1,342.06		
Fees—Auditing .....	300.00		
Salaries .....	12,000.00		
Insurance .....	554.25		
Postage, stationery and supplies, etc. ....	1,929.52	876,531.57	19,264.05
		<u>876,531.57</u>	
December 31, 1970—Balance—To Exhibit A .....			<u>35,458.82</u>



## WOMAN'S AUXILIARY

*Mr. President and Members of the House of Delegates:*

As President, it has been my privilege to attend to the affairs of your Auxiliary for the past year. I have also been privileged to have been included in the Med-Chi Program and Arrangements Committee meetings. Mrs. Leonard Warres has served very capably as a liaison member with the Med-Chi Public Relations Committee. Communication is vital to both you and the Auxiliary in order to accomplish worthwhile goals.

Four state auxiliary board meetings were held in addition to the Semiannual Meeting and the present convention. The highlights of the Semiannual Meeting were the Hobby Corner and providing the entertainment that hopefully brightened and lightened the meeting for you. We had fun planning the entertainment and hope that you enjoyed it.

As an ex-officio member, I attended eight Program and Arrangements Committee meetings. At the request of the committee chairman, I made special trips to Ocean City and Hershey, Pennsylvania in connection with the Semiannual Meeting held last September.

One of my duties as President is to represent the Auxiliary at conventions of surrounding states. My travels carried me to Delaware, New Jersey, New York, Pennsylvania, West Virginia, and the Eastern Shore of Virginia. Due to conflicting dates, I was not able to accept invitations to attend the meetings of the District of Columbia or Virginia. Official visits were made to each of the eleven component auxiliaries of the state of Maryland.

Please accept my gratitude on behalf of the Auxiliary for your continued financial support of \$1,000. Without your support and the valued assistance of "our Miss Wynde" and the rest of the staff at Med-Chi, we could never survive. I also want to thank you for joining us in co-sponsoring and co-signing a charter for the Health Careers Club of Maryland. There were 39 high school clubs with a total of 750 students affiliated with the state this year. It behooves all of us to encourage more young people to enter the medical and allied professions. The Health Careers Club is one of many ways to disseminate information on medical careers to interested students of junior as well as senior high school age.

Rather than a state AMA-ERF project (Laurel Day at the Races the past two years), we encouraged individual auxiliaries to develop their own projects in their own areas. We did continue the Christmas card sales as usual and also sold AMA-ERF stationery supplies given to us by the national headquarters of AMA-ERF in Chicago.

As of March 28th, the total raised by the Auxiliary amounted to \$3,079.03. More donations are coming in and will raise the total to at least equal last year's total of \$4,547.40. These figures do not include physicians' contributions made through Med-Chi.

Some of our members participated in workshops leading to the White House Conference on Children and Youth, but were not participants of the actual conference held in Washington, D.C. Mrs. Jonathan Williams,

National Auxiliary Chairman of the Mental Health Committee, attended the conference representing Maryland.

Med-Chi and the State Department of Health approved material concerning immunization that the Auxiliary Community Health Chairman used to publicize Community Health Week, October 18-24, 1970 on the radio and through other news media.

Doctor's Day (March 30) was observed by every component auxiliary. The various ways used to honor our husbands included carnations in offices or hospitals, or both, luncheons, cocktail-dinner parties, and dinner-dances.

With the help of the Med-Chi staff, our enthusiastic and energetic International Health Chairman planned and carried through an ambitious project to raise money for the S.S. HOPE which is now listing Baltimore as its home port. Arrangements were made for a private tour of the ship, followed by a cocktail buffet dinner held at Martin's West. Some 200 physicians and their wives were present at the evening function and enjoyed the open bar, music, special decorations, food, style show, and raffle. The date, January 2, was the only date available to us for touring the ship. This project was jointly sponsored with Med-Chi. The date was not particularly good (weather and otherwise), and we were disappointed with the poor attendance. Such a worthwhile project deserved support and I'm sorry more members of Med-Chi and the Auxiliary were not present. Despite the obstacles of poor weather and apathy, we did end up with net proceeds of over \$600 to forward to S.S. HOPE. The auxiliary donated an infant croupette and some component auxiliaries gave miscellaneous items such as johnny coats, bandages, and bed linens.

One of our priority committees was legislation this year. Members of the committee (representatives from each county) were invited to spend a day at the State House during the spring. After our visit and luncheon, we were privileged to have Aris Allen, MD, Delegate from Annapolis, speak to us on several pending bills in the legislature. A few of the component auxiliaries also made a trip to Annapolis a part of their activities for the year.

We also focused our efforts on community service and encouraged individual members to serve where needed in the local area. Service as defined included P.T.A., church, hospital, service agencies, as well as the diverse area of preventive medicine on a community level.

We continue to be concerned with membership. Our biggest stumbling block in retaining old members as well as attracting new ones is physician disinterest and apathy. Without encouragement from the physicians on behalf of the cause of their Auxiliary, one cannot expect much enthusiasm from the physician's wife to be a member.

My experience this year has suggested to me that in many instances the physician has actively discouraged his wife from participating in Auxiliary affairs, and this can only be interpreted as a lack of understanding as to the aim and purpose of the Auxiliary. Needless to say, this aspect of my term has been somewhat disheartening



to me as it doubtless has to those presidents I've followed.

Hopefully, if we continue to persist in our work we will eventually reach each physician and his wife and will achieve our full potential as an auxiliary.

Allow me to paraphrase a statement made by Mrs. R. C. L. Robertson, National President of the Auxiliary, to the American Medical Association: "Every physician should realize that the medical Auxiliary is actually connected to his livelihood. This is the organization most closely related to the physician's consuming interest—the good health of the people." This clearly defines the most important reason for a medical Auxiliary.

Respectfully submitted,

MRS. RAYMOND M. YOW, *President*

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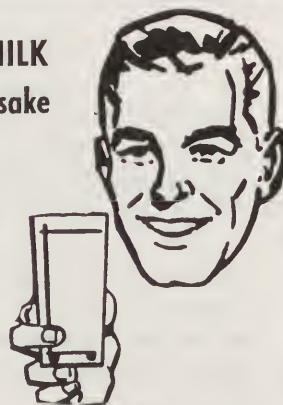
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## your medical faculty at work

by John Sargeant  
Executive Director

The Council met on Wednesday, May 12, 1971, at 9 AM at the Baltimore Civic Center, immediately before the House of Delegates session, and took the following actions:

1. Adopted minutes of previous meetings;
2. Heard a plea from retiring Council member Arthur G. Siwinski, MD, to continue fighting the encroachment of government on the practice of medicine.

**The Council met again on Friday, May 14, 1971, immediately following adjournment of the House of Delegates session, and elected the following as chairman and vice-chairman:**

Manning W. Alden, MD, Annapolis, Chairman  
John M. Dennis, MD, Baltimore, Vice-Chairman

**The House of Delegates in two sessions at the annual meeting took the following actions:**

1. Received greetings from the presidents of the medical societies of Delaware, New Jersey, Virginia, and West Virginia;
2. Observed a moment's silence in memory of deceased colleagues;
3. Presented 50-year pins to the following members who were present at the session:  
    E. W. Ditto, Jr., MD, Hagerstown  
    Bender B. Kneisley, MD, Hagerstown
4. Approved Emeritus Membership, on recommendation of component societies, for the following:  
    Baltimore City: Louis C. Dobihal, MD  
                    R. Walter Graham, MD  
                    Sigmund R. Nowak, MD  
                    Alexander A. Weinstock, MD  
    Sykesville (Carroll County): Ilse Kamm, MD  
    Glen Arm: Caroline A. Chandler, MD
5. Received the 1971 budget for information and was advised that the books had been audited for 1970, and a copy of the printed audit would be available at the Semiannual Session;
6. Adopted various Bylaw amendments, including one that would increase dues for the 1972 dues year for active members by \$20 in each of the categories designated for active membership;
7. Adopted a resolution for an indefinite assessment of \$5 a year, starting in the 1972 dues year, for the purpose of medical education;
8. Adopted a resolution honoring Guy M. Reeser, MD, of St. Michaels, who died on October 1, 1970;
9. Recognized the following deceased members for their outstanding contributions to Maryland medicine:  
    Robert W. Buxton, MD, Baltimore  
    Frank E. Shipley, MD, Savage
10. Received the Nominating Committee report and, at the Friday session, elected the following slate of officers:

*President-elect*  
DEWITT E. DELAWTER, MD, Bethesda { President-elect 1971-72  
President 1972-73 }

*First Vice President*  
EDWIN R. RUZICKA, MD, Easton (1973)

*Second Vice President*  
KATHERINE H. BORKOVICH, MD, Baltimore (1973)



*Third Vice President*

MANNING W. ALDEN, MD, Annapolis (1973)

*Secretary*

WILLIAM A. PILLSBURY, MD, Timonium (1973)

*Treasurer*

KARL F. MECH, MD, Baltimore (1973)

*Councilors*

*Central District*

LOUIS J. KOLODNER, MD, Baltimore (1975)

LOUIS J. KOLODNER, MD, Baltimore (1971-72)

(to fill unexpired term of Robert C. Kimberly, MD, resigned)

*South Central District*

FREDERICK E. MUSSER, MD, College Park (1975)

*Southern District*

ELMER G. LINHARDT, Annapolis (1975)

*Western District*

RICHARD Y. DALRYMPLE, MD, Westminster (1975)

ROBERT J. THOMAS, MD, Frederick (1975)

*Delegate to the American Medical Association*

ROBERT V.L. CAMPBELL, MD, Hagerstown (Jan. 1, 1972—Dec. 31, 1974)

*Alternate Delegate to the American Medical Association*

WILLIAM CARL EBELING, MD, Towson (Jan. 1, 1972—Dec. 31, 1974)

*Committee on Program and Arrangements*

EDWIN H. STEWART, MD, Baltimore (1972-76)

*Library and History Committee*

KATHARINE A. CHAPMAN, MD, Kensington (1972-77)

*Finney Fund Committee*

D. C. W. FINNEY, MD, Baltimore (1977)

11. Heard a report from the president of the Woman's Auxiliary to the Faculty on the Auxiliary's activities during the past year;
  12. Referred Resolution 1A/71 to the Policy and Planning Committee;
  13. Adopted Resolution 2A/71;
  14. Adopted, after amendment, Resolution 3A/71;
- (Copies of the resolutions may be obtained from the Faculty Office)

**The Medical and Chirurgical Faculty met in a general session on Thursday, May 13, 1971, at 12 noon at the Baltimore Civic Center, and elected the following to serve on the Board of Medical Examiners for a four-year term from June 1971:**

J. Roy Guyther, MD, Mechanicsville  
Gerald A. Galvin, MD, Baltimore

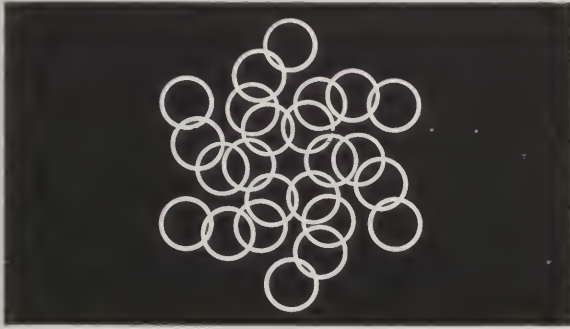
**The Executive Committee met on June 17, 1971, and took the following actions:**

1. Declined to continue membership in the Maryland Public Health Association as a sustaining member because of 1971 budgetary limitations;
2. Authorized participation in the Maryland Health Careers Promotion Council at a cost of \$25, on a trial basis;
3. Declined to participate in a fund drive for Center Stage, because this was outside the scope of Faculty activities;
4. Declined to provide matching funds to a component society for expenses involved in sending a member to a national conference on drug abuse; on the basis that such action would establish a dangerous precedent, and because all components would be eligible for such matching funds;
5. Established a policy that employees with a National Guard or military reserve obligation be paid the difference between their military pay and their regular salary for a maximum of 60 days (total days, not working days) each year; and that this not be cumulative year to year;
6. Deferred action in connection with establishing criteria for the award to be made under the provisions of the Laughlin Fund;



7. Declined to take action on a request dealing with hospital medical staff bylaws that would require representation from each department within the hospital on the Executive Committee of the medical staff. It determined this was a question for each hospital medical staff to decide.
8. Adopted the following policy on pronouncement of death:  
 "Unless exceptional circumstances warrant otherwise, it is good medical practice and good medical ethics that a body be identified, viewed and death verified before or at the time of pronouncement of death."
9. Endorsed the proposed regulations of the Department of Health and Mental Hygiene dealing with day care centers. This was done at the recommendation of the Faculty's Subcommittee on Child Welfare;
10. Adopted the following statement concerning the use of medication in the treatment of children with learning disabilities, behavioral disorders, and emotional problems:  
 The use of medication in the treatment of children with learning disabilities, behavioral disorders, and emotional problems is becoming more common. The recent discussion in the news media of the indiscriminate use of such medication is unfortunate in that it suggests to many worried parents that any use of such medication is wrong and it fails to note the many children in whom proper use of medication has prevented permanent educational and emotional damage.  
 The diagnosis of learning, behavioral and emotional problems in children is neither simple nor easy. There are many possible origins and treatment methods are different. The identification, study and management of these complex disorders would be a cooperative effort of physician, psychologist and educator. The use of medication must be only a part of the care of such a child but must be preceded by thorough medical examination.  
 If you think your child has a learning, behavioral or emotional problem, talk to your pediatrician or family doctor, let him guide you in affirming the existence of such disorder and its appropriate treatment.  
 This was done on the recommendation of the Subcommittee on Child Welfare;
11. Referred to the Board of Medical Examiners a request for a representative from this group to serve on the Advisory Council to MEDIHC (Military Experience Directed Into Health Careers). The Faculty's representative on this Council is the Faculty Secretary;
12. Designated the Peer Review Committee chairman to be its representative on a planning group of the Regional Medical Program currently developing a Uniform Hospital Discharge Data Abstract System;
13. Designated the Public Relations Committee chairman or a committee member designated by the chairman to serve on a Regional Medical Program Committee dealing with patient education;
14. Directed the Executive Officer of the Faculty to pursue with the Secretary of Health and Mental Hygiene the question of direct representation in some form on the Comprehensive Health Planning Agency;
15. Approved a cooperative effort with the Department of Health and Mental Hygiene in connection with a measles alert directed to all physicians. This was done on the recommendation of the Subcommittee on Immunization Projects;
16. Determined to seek more adequate representation of physicians on the Maryland Emergency Care Advisory Council, which now consists of 22 people, only three of whom are physicians representing the Faculty;
17. Directed the New Building Committee, under the chairmanship of Russell S. Fisher, MD, to seek other possible sites for location of a new Faculty building; and to report within 30 days;
18. Agreed to co-sponsor, along with the American Medical Society on Alcoholism, a meeting on Alcoholism scheduled for October 29 and 30, 1971, at The Johns Hopkins Medical Institutions.
19. Heard that former President and AMA Delegate, J. Sheldon Eastland, MD, is a patient at Mercy Hospital and is recovering from major surgery. It expressed concern and wishes for a speedy recovery;
20. Authorized the Program and Arrangements Committee to extend an invitation to the DC Medical Society to attend the Semiannual Scientific sessions of the Faculty to be held in Puerto Rico;
21. Also authorized the same committee to make any changes necessary in the 1972 Annual Meeting dates in order to secure the Civic Center for this session. It has been impossible to complete arrangements for this meeting, originally to be held at the Hunt Valley Inn.





From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# The Maryland Program For Training Alcoholism Counselors

GLADYS AUGUSTUS, BS, MED  
Co-Director  
Alcoholism Counselor Training Program  
Baltimore City Health Department  
Baltimore

To begin this article on the Maryland Program for Training Alcoholism Counselors, I would first like to answer a few questions that are often asked about the program. One thing we are often asked is: Do you train people solely for the state of Maryland? We are under a grant from the National Institute for Mental Health and, consequently, train for the entire United States. I invite applications from anywhere within the borders of the country. The second question often asked is: What are your basic requirements? Our basic requirements are a high school diploma or the equivalent; however, we have trained people with bachelors degrees, masters degrees, and one, two, or three years of college. The period of sobriety that is required for a counselor who is an acknowledged alcoholic is often questioned. We have accepted people with less than two years of sobriety, even though it is stressed in our project that an alcoholic must have at least two years' sobriety. These people were not accepted under the NIMH grant. They came either through a poverty program or under private sponsorship. In each case, it was a failure. It has proved that there must be at least two years' sobriety; some insist that there be three years.

The applicants give us personal references. If there are questions, we call them in for an interview prior to the meeting with the Admissions Committee. What are we looking for in this meeting with the Admissions Committee? We are interested in whether the applicant is "people-oriented" rather than "thing-oriented," ie, "people-people." Each member of the committee is looking for a particular quality. For instance, I am looking for the potential to communicate, ability, appearance, and a fund of

general knowledge. These are the things a teacher would like to see in a potential student. We have two psychiatrists on the admissions committee. I am certain they are looking for something quite different. We also have an A.A. member on the committee. In sharing the information, we get a variety of well-rounded people.

### Trainees

What do we do with these trainees during the six-month period? The first two months are strictly lecture months—lectures in the alcoholism center. The first month is devoted entirely to alcohol, alcoholism, and the alcoholic; the second month

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to counseling and counseling techniques. Each member of the staff serves as a lecturer and group leader according to his particular expertise. The director lectures on most of the physical, psychiatric, and treatment aspects of alcoholism (I handle a great deal of the counseling philosophy and techniques). Visiting resource personnel complete our lecture schedule. They are specialists in medicine, nursing, psychiatry, psychology, education, law enforcement, and correction. Some are from the Department of Social Services. They may work on a municipal or state level. Most of our resource staff is paid in reciprocal services only.

We work very closely together; I work on the city level, others on the state level. Any time that one of us needs the services of the others, we call and ask if they are free to come and help out on a particular date. We have never had any differences about time allotments and salaries; it is an ideal arrangement. We are very fortunate to have this reciprocity in Maryland. It is rewarding to realize that a substantial number of people are willing to give freely of themselves and of their knowledge whenever time permits such a program.

In the same building, we have the Baltimore City Health Department, the Alcoholism Clinic, the office of the Coordinator of Alcoholism Programs, and the Department of Parole and Probation's Alcoholism Unit (which deals with law violators who also have a drinking problem). We hold group meetings at the center nightly; one night a week Alcoholics Anonymous holds a session. In addition to having all these activities within our center's building, we are only ten minutes away from two of the general hospitals we use for training and five minutes away from the Department of Social Services, two halfway houses for women and two halfway houses for men, and one 12-step house.

We have a director who is medically as well as psychiatrically oriented, a psychiatric social worker who is interested in alcoholism, and a senior alcoholism counselor who has a number of years experience in the state hospital system. The staff also includes an Episcopal priest who is also a lawyer.

#### **Human Interrelationships**

Within the program, we do a great deal of work on human interrelationships. Each of us has his own biases and prejudices and we believe that you cannot work with another person's problems until you are able to recognize your own. We explore these with the trainees. We also have people in our program from all socioeconomic levels. We have people from the community agency poverty programs and people who come from higher socioeconomic levels. This diversity is what makes our training program work effectively.

At the end of the two-month period, the trainees are placed in field assignments usually in pairs, for a four-month period. As the program expands, general hospitals are recognizing our program and requesting our counselors, as are the state hospitals. We now serve Johns Hopkins Hospital, the University of Maryland Hospital, the Veterans' Hospital, the United States Public Health Hospital, and the nearby state hospital. One-half day a week during the field work assignment is spent at the center with the staff sharing, reviewing, and venting emotions, and learning further. At the conclusion of each training period, each trainee must attend The Johns Hopkins School of Public Health and Hygiene's two-hour public seminar, a therapy session at our center, and a two-hour session at the Psychiatric Institute at the University of Maryland. Trainees also spend time in court with the Municipal Court Alcoholism Counselor, and four weekends in an emergency room of a general hospital.

Since the inception of this training program, the Baltimore City and Maryland State Civil Service Commission have created a classification of Alcoholism-Counselor with specific requirements, job description, and a range of salary up to \$8,562 a year.

The majority of the positions have been filled by our graduates. The agencies that have employed our trainees as alcoholism counselors are the Baltimore City Health Department, Maryland Department of Mental Health, General Hospital-Baltimore City, Johns Hopkins Hospital, University Hospital, Provident Hospital, the Federal Rehabilitation Center, and Community Action Agencies and Correctional Institutes in Maryland and Tennessee. Of the 60 trainees who have successfully completed our training program, 55 are presently working in the field of alcoholism either full-time or part-time.

#### **Quarter-Way House**

We also set up a Quarter-Way House at Johns Hopkins after two trainees of our Center were successfully included on its staff. The Quarter-Way House was founded by the State Department of Mental Hygiene. It is coordinated by a nurse who operates between the hospital and the Quarter-Way House. Once the patients are treated in the emergency room, those not ill enough to remain in the hospital may be referred to the Quarter-Way House, where they may stay for 14 days. This Quarter-Way House is staffed primarily by alcoholism counselors. A Quarter-Way House serves a very valuable function. It is not a detoxication center; it is, rather, a rehabilitation center. Medical emergencies as well as less severe medical situations are being taken care of now with the cooperation of the Department of



Mental Health, the hospitals, the halfway houses, the Quarter-Way House, and the counseling program.

Our experience with the training program during the first two years since its beginning on September 25, 1967, suggests that many opportunities for secondary gain have been afforded. For example, by inviting representatives of help-providing agencies to serve as lecturers and consultants in their respective fields, we increase the trainees' knowledge of the program of the particular agency. We also make the lecturer aware of the clinic as a community resource, and we have an opportunity to discuss the clinical program with him. The lecturer too shares this information with the workers in his agency, thus leading to more appropriate referrals to the clinic. Similarly, through field placements, we are developing a network of liaison workers, which greatly facilitates the referral of patients from one facility to another and vice versa, frequently averting the loss of patients during the referral process.

Another secondary gain is the creation of a need for alcoholism counselors through demonstration of their activities and usefulness to the agency during their field placement. This is reflected in the fact that many agencies have included in their budgets

requests for positions for alcoholism counselors. This also reflected in the creation of the civil service classification on both state and city levels.

### A Change In Attitude

The training program has played an important role in the creation of a state-wide alcoholism program. It has been preparing and making available the necessary manpower to back up developing programs, creating a demand for alcoholism counselors, stimulating helping agencies, hospitals, jails, and so forth to develop alcoholism programs, helping to improve the general hospital staff's attitudes toward the alcoholic patient, and helping to improve the treatment of the alcoholic patient.

One final facet of the program that interests me is the beginning of a program with the community colleges in our area. These community colleges offer an Associate in Arts Degree for the two-year program. We are trying hard to get a program on alcoholism counseling initiated. Such a program would lead to a baccalaureate in alcoholism counseling. Hopes such as these for new areas of expanding our program—in addition to the sense of accomplishment in looking back over the past 2½ years, make being a member of this alcoholism-counselor training program a very rewarding one.

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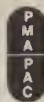
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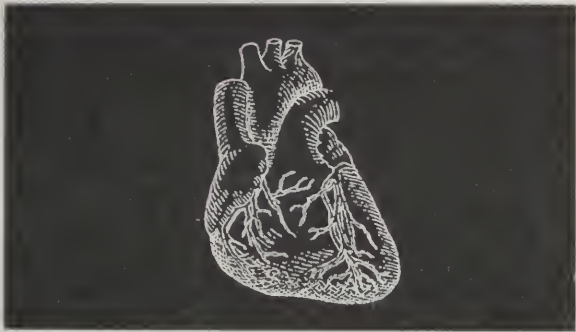
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MORRIS N. KOTLER, MD, EDITOR

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## **the heart page**

# **The Significance of Ventricular Dysrhythmias In Men After Myocardial Infarction**

MORRIS N. KOTLER, MD  
BERNARD TABATZNIK, MD  
Sinai Hospital,  
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The experience gained in coronary care units has led investigators to believe that sudden and unexpected death in patients with coronary heart disease is largely the result of electrical instability culminating in ventricular fibrillation.<sup>1</sup> Ventricular ectopic beats occur in 80% of patients with acute myocardial infarction and are enhanced by bradycardia and heart failure.<sup>2</sup> Frequent ventricular ectopic beats, salvos, multifocal and early premature ventricular beats together with ventricular tachycardia invariably precede ventricular fibrillation.<sup>2-3</sup> Despite the high overall hospital mortality for patients developing dangerous ventricular dysrhythmias in the coronary care unit, prompt recognition and treatment of ventricular ectopic beats is an important factor in determining the effectiveness of the unit.<sup>4</sup>

As many as 30% of all hospital deaths from acute myocardial infarction occur after the sixth day following discharge from the coronary care unit.<sup>5</sup> At least half of these deaths are sudden and unexpected.<sup>5</sup> Significant serious ventricular dysrhythmias may occur after the acute phase of myocardial infarction<sup>6-7</sup> on the basis of persistent electrical instability of the heart muscle or perhaps are the result of a further ischemic episode<sup>7</sup> or fresh infarction.<sup>8</sup>

In those men who are alive one month after an acute myocardial infarction, there is an 81.4% survival rate at the end of 4½ years.<sup>9</sup> For many years, the approach to those patients surviving an acute myocardial infarction was to prevent recurrent thrombosis by the use of long-term anticoagu-

lants.<sup>10-12</sup> While there is still controversy concerning the efficacy of long-term anticoagulants in preventing reinfarction,<sup>13</sup> there is general agreement that sudden death in this group of individuals is not altered in those patients receiving long-term anticoagulants as compared with those patients receiving placebo.<sup>10-12</sup>

### **The Logical Approach**

The newer, more logical approach would be to try and identify the high-risk patient postmyocardial infarction. It is estimated that 50% of those patients dying in the first year after discharge from the hospital die suddenly, presumably from a cardiac arrhythmia.<sup>4</sup> Denborough, et al, reported that 20% of patients with major arrhythmias during

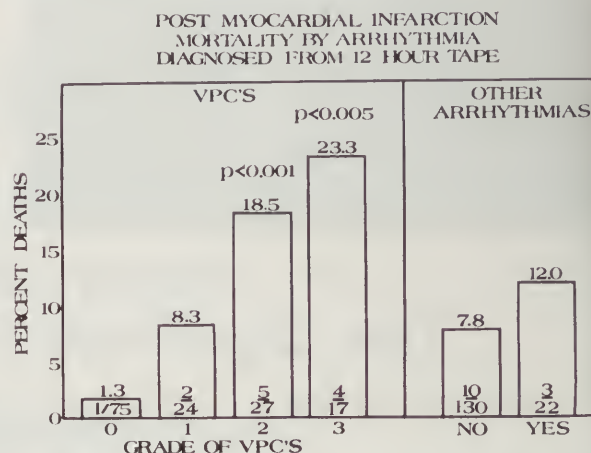


the hospital stay for acute myocardial infarction died suddenly in follow-up of up to three years, compared with only 7% of those patients who had no arrhythmia recorded.<sup>14</sup> However, in this study, 50% of patients had major conduction disturbances and heart block and the long-term prognosis may be related to the amount of myocardial involvement, rather than to the original rhythm disorder.

In order to try and identify this high-risk group, we recently undertook a study analyzing resting 12 lead electrocardiograms and 8 to 12 hour tape recordings during routine activity<sup>15</sup> in 160 men patients between the ages of 30 and 64 who had a previous myocardial infarction and were either in Class I or II (according to the NYHA Classification). By the end of 1970 with an average follow-up period of 24 months, there were 13 deaths, ten of them being sudden and unexpected. With respect to known coronary risk factors including blood pressure, weight, serum cholesterol, triglycerides, fasting blood sugar, uric acid, physical activity, and smoking habits, there was no striking difference between the group who died as compared to the survivors.

Analysis of 660 ECGs on 160 patients after myocardial infarction revealed that 33⅓% had ventricular premature beats, an incidence that increased to 56% when patients were continuously monitored under various conditions over a period of 8 to 12 hours. The percentage of deaths in patients with no premature ventricular beats was 1.3% and with grade I (ten an hour) it rose to 8.3%, which is not statistically significant. However, with grade II (11 or more an hour) and with grade III (multifocal), the percentage of deaths rose to 18.5% and 23.3%, which is statistically significant (Figure 1). Because of the limited number of grade IV (salvos) and grade V (paroxysms of ventricular tachycardia) arrhythmias in this study group, statistical analysis

could not be undertaken. With respect to supra-ventricular arrhythmias and conduction disturbances, there was no statistical difference between the survivors and those who died.



**Figure 1: The increase in percentage of deaths associated with the grade of ventricular premature beats. In addition, no significant difference was noted when other arrhythmias were compared.**

Before we can begin to understand the problem of sudden death in the patient with previous myocardial infarction, there is an urgent need to evaluate what happens to those patients with ventricular dysrhythmias during stress and during recurrent ischemic episodes. In addition, the efficacy of long-term antiarrhythmic drugs (singly or in combination) in suppressing ventricular dysrhythmias needs to be studied. Because of the limited number of patients involved in our study, larger and collaborative nation-wide studies are mandatory to determine whether this preliminary trend exists in the post myocardial infarction cohort.

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NEIL SOLOMON, MD, PhD, SECRETARY

## Maryland State department of health and mental hygiene

# Testing For Hepatitis-Associated Antigen

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**Baltimore**

The seriousness of posttransfusion hepatitis is well established. Preventive measures in the past have included excluding donors with a history of hepatitis, and those donors whose transfused blood has resulted in a case of hepatitis. Early in 1971, the Maryland State Department of Health advised every blood donor center to establish a file of such donors to prevent their future donations or, if their blood is taken, to prevent its use for transfusion. (An opinion from the Assistant State's Attorney General held that information identifying such donors may be provided to other blood donor centers. The basis for this opinion was that the relationship of a donor to the physician-director of a blood bank is not a physician-patient relationship and such information, therefore, is not privileged.)

The development of techniques for testing donors for the hepatitis-associated antigen [HAA] (also called Australia antigen), is beginning to provide an additional laboratory means for identifying a significant proportion of carriers of viral hepatitis. The antibody reagent for performing this test was first federally licensed on February 19, 1971, and the methodology, while being actively improved, has not yet been developed where the apparatus or methods can be optimally recommended. In January and February 1971, antibody from National Institutes of Health sources was distributed as an experimental drug for study purposes in anticipation of the availability of licensed antibody, and of suitable apparatus for purchase.

An authoritative statement of the current status was published April 16, 1971 in the *Weekly Report of Morbidity and Mortality* (Vol. 20, No. 14) issued

by the Center for Disease Control, U.S. Department of Health, Education, and Welfare, Atlanta, Georgia. Pertinent extracts are quoted below from this published report on "Current Trends—Routine Testing in Blood Banks for the Hepatitis-Associated Antigen", prepared by a nine-member committee of the National Academy of Sciences—National Research Council (T. C. Chalmers, Chairman):

"It is important to recognize that HAA testing has moved from the experimental laboratory to the blood bank with extraordinary rapidity."

### Various Methods

In discussing various methods—the counter electrophoresis [CEP] (formerly called immunoelectrophoresis [IEOP]), the agar-gel diffusion [AGD], the complement fixation [CF], the indirect hemagglutination inhibition [HAI], and the radioimmuno-



assay [RIA] tests—the report continues:

“The committee recommends:

1. That, as soon as practicable, all blood banks begin routine HAA testing of blood donors with commercial supplies of antiserum licensed by the Division of Biologics Standards or with locally prepared antisera of equivalent quality, recognizing that rapid and possibly fundamental methodologic changes may occur in the next few years. *A commercial antiserum should be used only with the test methods for which it is recommended.*

2. That, if test results are required rapidly, blood banks introducing routine screening begin with the CEP test. The AGD test is useful if test results are not needed rapidly, and it could be used for confirmatory tests in reference laboratories.

3. That the CF, HAI, and RIA tests not be adopted for general use in blood banks unless procedures are developed that make them practical. (However, laboratories and blood banks that are already using, or have capabilities to begin using, these tests are encouraged to do so.)

In offering the above recommendations, the committee is impelled to emphasize that in the current state of the art, routine HAA testing of blood donors is not the final and complete solution to the hepatitis problem. Certainly, it is good medical practice to identify, by any practical means, prospective donors whose blood may transmit hepatitis to a patient and to disqualify them as donors. Currently, even in the best of hands, the most sensitive test identifies only a portion of such persons.

The committee also wishes to emphasize that the introduction of routine HAA screening in the nation's more than 5,000 blood banks involves procedural problems that should be dealt with vigorously and promptly at all administrative and professional levels.”

The committee also recommends training courses

for testing, and development of quality controls. As to the finding in the next year of perhaps 10,000 persons in apparent good health who are HAA-positive, they should be informed of their condition and instructed not to donate again. The question of what medical advice to give them requires urgent follow-up research.

### Training Workshop

The Maryland State Department of Health conducted a training workshop on January 23, 1971 for representatives of all of the 55 blood banks in Maryland. All blood banks were encouraged to begin testing at the earliest possible opportunity. In line with the opinion of the Division of Biologics Standards of the National Institutes of Health, clarified by a release on April 13, 1971 (to the effect that federal regulations would require, at the earliest possible date, HAA testing in all blood banks for interstate license) the Maryland State Bureau of Laboratories announced on February 25, 1971 that such future regulations in Maryland were contemplated, but not at the present state of development of the test.

The Maryland Bureau of Laboratories performs the test for cases of hepatitis routinely and provides support and consultation for blood banks in their attempts to initiate testing. A register of HAA-positive persons has been recommended for each blood bank, and the Bureau of Laboratories is centralizing such a register for donors at commercial blood banks.

Of epidemiologic interest is that cases of serum and infectious hepatitis *reported* nationally for 1971, up to May 1, totaled was 23,327, a 50.4% increase over the previous five-year median. Cases reported in Maryland in 1971, up to April 15, totaled 406, a 77.3% increase over the five-year median for this period of the years.

## Immunization Requirements For Travelers

HOWARD J. GARBER, MD

Chief

Division of Communicable Diseases

State Department of Health and Mental Hygiene  
Baltimore

A valid International Certificate of Vaccination against smallpox is required for entrance into most foreign countries and for re-entry into the United States for travelers visiting countries reporting smallpox. To be valid, the vaccination must have been done in the last three years.



The vaccinating physician must record the vaccination on the International Certificate of Vaccination as follows:

1. Under *Date*, write the date the vaccination was done. The date should be written in the European form; ie, day, month, and year, in that order, eg, 1 January, 1970.
2. Whether the vaccination was primary or secondary; if primary, whether or not it was a "take."
3. Signature and address of the physician.
4. The manufacturer of the vaccine and the control or lot number on the vaccine vial.
5. The validation stamp of the state, county, city health department, or one issued by the State Department of Health and Mental Hygiene.

It is important to emphasize to travelers the advisability from their own point of view of having a valid certificate. Any American traveling on an airplane with an infected person, or returning from a country reporting smallpox within the previous 14 days, could be subjected to quarantine up to 14 days in the first port of debarkation if he lacks a properly completed valid certificate. This quarantine might take place in a foreign country. Travelers without valid certificates arriving from smallpox-infected areas, or exposed to smallpox enroute, will be vaccinated at the port of debarkation in addition.

No certificate is required to or from: Aruba, Bahama Islands, Barbados, Bermuda Islands, Bonaire, British Virgin Islands, Canada, Curacao, Dominican Republic, Cayman Islands, Greenland, Haiti, Iceland, Jamaica, Leeward Islands (Antigua, Barbuda, Redonda, St. Kitts, St. Martin, Nevis, Anguilla, Montserrat, Guadeloupe), Mexico, Miquelon Island, Panama Canal Zone, St. Pierre Island, Trinidad and Tobago, Windward Islands (Grenada, St. Vincent, the Grenadines, St. Lucia, Dominica, and Martinique), or the United States and its possessions.

A person who must not be vaccinated because of the following contraindications (1) eczema and other forms of chronic dermatitis in the individual or in a household contact, (2) an altered state of immunity due to serious disease or during treatment, and (3) pregnancy, should request from a physician a signed letter indicating that, in his opinion, smallpox vaccination is medically inadvisable. The statement should be presented to the quarantine inspector on return to the United States who will determine what measures are necessary. Under usual circumstances, the traveler will be admitted without delay. However, if there is a serious risk of exposure, then the unvaccinated individual may be vaccinated or placed under local surveillance or quarantined.

The physician who does the vaccination should be extremely careful about the vaccine which he uses. Vaccine which is nearing the date of expiration marked on the tube or vaccine which has been kept

more than a few hours without refrigeration should be discarded. Smallpox vaccine will deteriorate very rapidly at very warm temperatures. The physician's supply should be kept in the freezer compartment of his icebox.

The International Certificate of Vaccination booklet may be obtained from your travel agent or the local health department.

Yellow Fever vaccine is recommended for persons six months of age or older traveling to endemic areas—primarily Africa and South America. Some countries require a valid International Certificate of yellow fever immunization for entry (or even if the individual is in transit), particularly if the traveler has been in an endemic area. This applies particularly to travelers going to South and Southeast Asia via the Atlantic. Yellow Fever vaccination centers are located in Maryland at Prince George County Health Department, Cheverly—301-773-1400, ext. 207; the Washington County Health Department, Hagerstown—301-739-0800; the Wicomico County Health Department, Salisbury—301-749-1244; and the U.S. Public Health Service Hospital, Baltimore—301-338-1100. The vaccination is valid for ten years beginning ten days after primary vaccination and on the day of revaccination if a ten-year period has not elapsed.

### **Cholera Vaccine**

Cholera vaccine is required for tourists traveling to countries reporting cholera, located principally in South and Southeast Asia and Africa. In addition, foreign countries without cholera present may require immunization for travelers. The local or state health department should be contacted for this information. The United States does not require cholera immunization for reentry into this country, even from countries reporting cholera. In general, cholera is present mainly in rural areas; therefore, the disease will not present a threat to the usual tourist or businessman. The International Certificate must be stamped by the health officer or other authorized official and is good for six months. On primary immunization, the certificate does not become valid until six days after the vaccine is given.

Poliomyelitis vaccination is recommended by the U.S. Public Health Service for all international travelers, although not required for entrance to any country. Each tourist, however, should be evaluated separately, taking into consideration the risk of polio in the area to which he is traveling, the age of the individual, his prior immunization status, and the type of polio vaccine which he has previously received.

For travelers seven years old and older, adult type tetanus vaccination (Td) is recommended for either primary immunization if the individual has never been vaccinated, or booster doses if he has not had



one in the previous ten years. For children six years old or younger, the complete series of diphtheria immunization (DTP) is recommended if the individual has never been vaccinated.

Measles vaccine is recommended for all children over one year planning to travel outside the United States who have not had measles (rubeola) or previous immunization with the vaccine.

For travelers visiting areas involving a high risk of infectious hepatitis (Africa, Asia, South America, Pacific Region, Philippines and South Pacific Islands, Central America, and rural Mexico) it is suggested that immune serum globulin prophylaxis be given within one to two weeks before departure. The dosage for short-term travelers (one to two months) under 100 lb is 1 cc and, over 100 lb, 2 cc.

Tourists traveling in malaria endemic areas should receive malaria chemoprophylaxis. This is a problem primarily in Africa, South and Southeast Asia, Asia Minor, most of Central America, and the countries in the northern half of South America.

Typhoid vaccine is no longer recommended for Europe or for other areas if the traveler stays at usual tourist accommodations. Typhus vaccine is recommended only for persons whose work abroad places them in areas where the local population is infected, and since the risk of typhus for United States travelers is extremely low, it is not recommended for the usual tourist. Pre-exposure immunization against rabies is not recommended for tourists or short-term visitors. Plague vaccine is recommended only for Vietnam, Laos, and Cambodia, unless the traveler will have occupational exposure to wild rodents in South America, Africa, or Asia.

#### SEROLOGIC TESTING FOR SYPHILIS

To suggest guidelines regarding the more recent developments in serologic testing for syphilis, the following information is announced. The State Public Health Laboratory currently performs three different serologic tests for syphilis. They are:

1. **Rapid Plasma Reagin Card Test (RPR)** This is

a screening test performed on all specimens submitted. It is not diagnostic for syphilis.

2. **Venereal Disease Research Laboratory Test (VDRL)** This test is routinely performed on specimens that react on the RPR Test. The VDRL is titrated and reported out as a quantitative reading; ie, weakly reactive, 1-1, 1-32, etc. These readings are valuable as a base line for subsequent serologic testing to determine treatment effectiveness. This test is not diagnostic for syphilis. False positive reactions frequently occur. Patients should not be treated on the basis of a reactive VDRL alone, and spouses and other sex partners of a patient with a reactive VDRL should not be interviewed until a false positive reaction is excluded by further testing.

3. **Fluorescent Treponemal Antibody Absorption Test (FTA-ABS)** This test is routinely performed on specimens that are reactive by either the RPR or VDRL Tests. This is the most specific and sensitive test used in the diagnosis of syphilis. Reactions that occur on the VDRL and the RPR Test, or both, but not on the FTA-ABS, are generally regarded as false-positive reactions due to causes other than syphilis. If the FTA-ABS is reactive, the indication is that the patient either had or has syphilis. Clinical staging of the disease must be determined by history and physical examination.

It is known that false-positive reactions may infrequently occur on the FTA-ABS. On this subject, however, the literature is scant. Most known false-positive reactions have been on specimens from patients who have had diseases associated with abnormal serum globulins.

In summary, the diagnosis of syphilis is usually made on the basis of reactive serologic tests and, in most instances, a reactive FTA-ABS test is essential for this diagnosis. The decision to treat or not to treat will still depend on clinical judgment.

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and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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T-107/4/71/US PATENT NO. 3,001,910



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## tuberculosis

# TB Testing Project Achieves Results

The Tuberculin Testing Evaluation Committee of the Maryland Tuberculosis and Respiratory Disease Association has announced the 21-month results of a three-year tuberculin testing program.

The project is being conducted as a demonstration to determine the feasibility and productivity of offering free tuberculin tests to a cross section of the local community. The program attracts those persons who would not normally report to an industrial or community mobile chest X-ray unit or a health department clinic for a chest X-ray.

Since the June 1969 inception of the program, 38,789 chest X-rays have been taken at the Mt. Royal Avenue testing center. Early in 1970, a more energetic and positive approach toward tuberculin testing was made when the Mantoux skin test was offered in conjunction with X-ray examinations. Subsequently, 48% of those receiving X-rays also accepted skin tests.

Commenting on the percentage of people receiving skin tests, Meyer W. Jacobson, MD, medical director of the program, said, "We are proud of our success in administering these tests. The response of the medical community has also been very gratifying; increasing numbers of physicians are sending patients to us for this procedure."

Of the 18,498 Mantoux tests administered, skin responses of 7,642 persons were "read" by health personnel at the center. Readings of 1,813 persons indicated a positive tuberculin exposure by skin reaction of 10 mm or more.

Correct administration of the Mantoux test provides highly accurate results and it is considered by many to be a superior method to both the Tine and patch skin tests. In addition, X-ray examinations are limited because they only indicate the present condition of the lungs. Skin tests, however, will manifest an exposure to tubercle bacilli which has occurred at any time during the person's life. This dormant bacilli may, during a period of physical debilitation, develop into an active case of tuberculosis.

The MTRDA has established a referral proce-

dure for patients with positive readings. Test results of these people are sent to their family physicians or to an appropriate health department of chemoprophylactic supervision. The suggested drug to be used in these cases is isoniazid (INH) in daily 300 mg dosages. Use of INH has been successful in 96% of the cases tested.

Funding of the MTRDA program comes directly from Christmas Seal contributions. Operating costs for the year ending March 1971 were placed at \$33,181, or approximately 56 cents a patient.

The testing program at the MTRDA screening center is scheduled to be phased out in March 1972; however, no final conclusion has been reached on this matter. It is hoped that through the success of this program, the skin testing technique will be more widely adopted by private physicians and local health departments.

### PROGRAM TOTALS

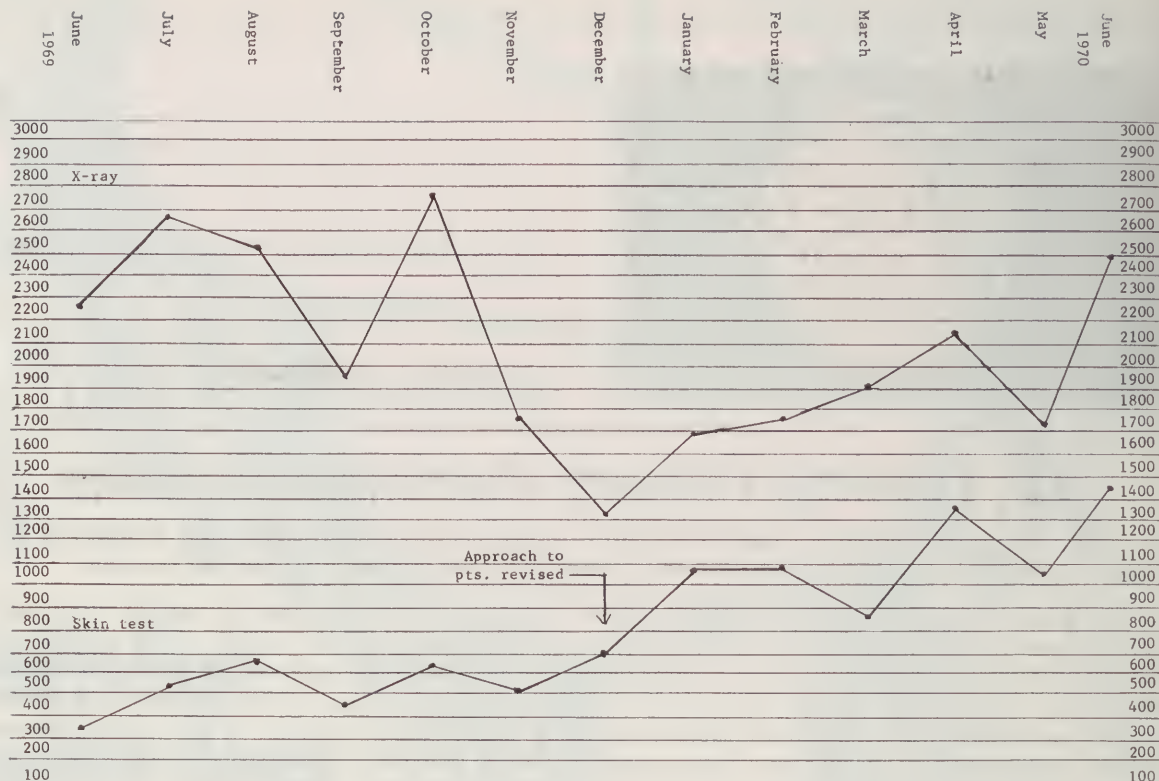
June 1969—March 1971

X-rays	38,798	
Skin Tests	18,498	48% of 38,798
Skin Tests—Read	7,642	41% of 18,498
Skin Tests—Called in	5,019	27% of 18,498
Readings 5 mm to 9 mm	646	8% of 7,642
Readings 10 mm +	1,813	24% of 7,642

In addition to Edmund G. Beacham, MD, who served as Chairman of the Baltimore City Tuberculin Testing Committee, the following members served:

George W. Comstock, MD  
Jean E. Hawkins, MD  
Meyer W. Jacobson, MD  
John H. Janney, MD  
Allan S. Moodie, MB, DPH  
Donald J. Roop, MD  
Donald R. Childs, MD





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## Baltimore City health department

# City Has Nation's First Nonfederal Layman to Screen Chest X-rays

Baltimore now has the nation's first nonfederal layman qualified to screen TB chest X-rays. Charles Trexel, a public health representative with the City Health Department's Division of Tuberculosis Control, has completed a ten-week training course at the National Center for Disease Control in Atlanta, Georgia. This course is designed to enable lay workers to identify normal chest X-rays and so extend the capacity of the physician.

It is planned that Mr. Trexel's duties will later include programming of the Mobile Chest X-ray Unit and screening of X-rays taken. This will permit simultaneous availability of tuberculin tests and nega-

tive chest X-ray findings as part of Baltimore's pioneer Industrial and Inner City TB Prevention Program.

This innovation plan of allied health professional X-ray screening is only one of many new ideas that have made Baltimore's tuberculosis control program a model for the entire United States. The Philadelphia Regional Office of the U.S. Public Health Service accords this program the highest efficiency performance rating reached by any major city in Public Health Service Region III comprising Delaware, Washington, D.C., Maryland, Pennsylvania, West Virginia, and Virginia.

## Two New Important Appointments

On April 22, Ross Sanderson was appointed by Baltimore's Commissioner of Health, Robert E. Farber, MD, as Assistant to the Commissioner of Health for administration. Mr. Sanderson was formerly assistant director of the Housing Bureau, Baltimore City Health Department, from 1951 to 1956. He has also held positions in the city's Zoning Division and the former Urban Renewal and Housing Agency. More recently, he was Director of the Neighborhood Development Division of the Department of Housing and Community Development.

In addition to his long experience with administrative matters in city government, Mr. Sanderson is a graduate of Oberlin College and holds a masters degree in business administration from the Wharton School of the University of Pennsylvania.

In his new assignment in the City Health Department, Mr. Sanderson will be responsible for personnel management, administrative management of purchasing, contracts, and general business operations.

Also recently, Marvin Jones, the City Health De-

partment's Administrator of Child Mental Health Services, has been appointed to a new position as the first full-time Administrative Health Officer for Mental Health Services for the City Health Department.

In his new post he will be responsible for the coordination and administration of all the health department's mental health programs and will be Executive Secretary of the Mental Health Advisory Council to the Commissioner of Health.

Mr. Jones first came to the Baltimore City Health Department in 1963 and served as a clinical psychologist for the City Health Department's Alcoholism Clinic. In 1966 he left the health department to become staff psychologist for the Supreme Bench of Baltimore. He returned in 1968 to supervise two full-time child mental health clinics and two part-time programs.

Mr. Jones' office is located in the American Building, Room 801, and he can be reached at 752-2000, extension 2777 or 2746.



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## Study Group Proposes Minority Enrollment Increase

A task force, sponsored by four major medical organizations, has issued a report outlining recommendations to increase substantially the number of minority group students in medical schools. This study group presented a plan by which medical schools could expand the minority student enrollment from the present 2.8% of the total enrollment to 12% by 1975 to 1976.

This recently prepared report was presented to the Inter Association Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students. The membership of this Committee included representatives from the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, and the National Medical Association.

This report proposes the establishment of an "educational opportunity bank" which would provide loans to all qualified medical students to finance their educational costs. Repayment would not commence until the student had entered his professional career. The terms of repayment would be based on an agreed percentage of income.

Although this report has been approved by the Inter-Association Committee, this does not constitute official endorsement by the four organizations represented on this committee.

*American Medical Association*

## Payments to Physicians Must Be Reported By Insurance Firms

The Internal Revenue Service has ruled that payment to physicians of more than \$600 must be reported to the IRS by Blue Cross, Blue Shield, insurance companies, and Medicare and Medicaid agencies. Also included are unions and employers with self-insured or self-administered health plans.

This means that insurance companies and other units paying \$600 or more a year to physicians or other persons rendering services under health plans must file annual "information returns".

According to the IRS, the payments when made directly to the physician are considered income which must be filed on tax returns.

*Appa Digest*



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## **rehabilitation medicine**

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# **Perceptual-Motor Dysfunction Stumbling Block To Rehabilitation**

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What does the future hold for today's stroke patient? Will he be discharged from the hospital emergency room to his bedroom to be cared for as a permanent invalid? Will he be placed in a nursing home to sit idly by a window, or will he be fortunate enough to receive prompt and appropriate early care and all that modern rehabilitation has to offer? Current teaching suggests that the latter avenue is the preferable one.

Even with the most modern rehabilitative procedures, however, there are many patients who fail to achieve the goals which are set for them and which their degree of motor return suggests are feasible. Too often, such failures are attributed to lack of motivation on the part of patient and family.

Most of us recognize that recovery of function following stroke entails a considerable degree of motor retraining. It is important, then, to look at the characteristics which are essential for functional motor reorganization and learning. Adequate treatment of the stroke patient depends on understanding of the perceptual motor process—a chain of events, separate in time, through which the individual selects, integrates, and interprets stimuli from his own body and from his environment. The result of a normally functioning system is successful interaction with the environment; the result of a faulty system is ineffectual behavior.

Research in the field of brain damage supports the thesis that stroke patients, as a group, share several basic deficiencies in common, irrespective of the hemisphere involved and the degree of consequent motor impairment.<sup>1-2</sup> These deficiencies occur

throughout the perceptual motor process, during all or any of the following four phases:

1. The preparatory set phase
2. The selection and integration of stimuli
3. The translation of static perceptions into efficient motor acts, and
4. The interpretation of results

Preparatory set formation defines those modifiers of response which are present within the individual before the presence of a perceived object or event. These modifiers include past experience, social expectations, and body awareness. This last is perhaps the most important.

### **Body Awareness**

To form accurate concepts about space, one must have an adequate knowledge of his body, its struc-



ture and movement capabilities. Body awareness is derived from the integration of tactile, proprioceptive, and interoceptive sensations and the person's own subjective experience of his body, which we refer to as body image. Another vital part of body awareness is the intellectual knowledge one has of his body parts and the ability to differentiate right and left sides of the body.

Adequate perception and integration of somesthetic stimuli are necessary for successful functioning, and relate to a person's body image, or his subjective opinion of himself. Self drawings of stroke patients often reveal aberrations in sensory perception and integration. Inequities are often reflected in incomplete, distorted, and immature bodily representations. It is well known that many stroke patients suffer from loss of proprioception, but there are other, more subtle distortions that are equally as disabling, such as loss of kinesthesia, astereognosis, and distorted tactile sensation. Too frequently, a strong arm is dismissed as being functional, without adequate assessment of sensory integration.

Occasionally, the phenomenon of physiologic denial of the left side of the body is observed in people with right hemisphere damage. Because of this lack of sensory integration, the task of rehabilitating such people is long and arduous. They may ignore the left side of the body while bathing and dressing, and have a great deal of difficulty establishing adequate sitting and standing balance. Ambulation, even between parallel bars, is almost impossible.

Frequently, irrespective of whether the patient has right or left hemisphere damage, well meant instructions to bend a left elbow or straighten a right knee are fruitless, either because the patient does not know the location of these body parts, or because his right-left discrimination is faulty. Some people learn to compensate for this deficiency through vision and rote memory, but have difficulty responding with their eyes closed.

As mentioned earlier, the patient must deal successfully not only with stimuli arising from within his body, but those impinging upon him from the outside environment. Here is where deficiencies in visual perception are noted. One of the areas which we have found to be consistently affected in brain-damaged patients is that of figure-ground discrimination. This is the ability to attend to the central idea or object of one's momentary experience apart from the surrounding field. The brain-damaged patient is often unable to sort out the relevant from the irrelevant. Such a person may be very easily distracted and consequently suffers from a short attention span. This type of deficiency is usually more of a disability than a paralyzed arm or leg, and has grave consequences as far as learning potential is concerned. Performing any task, whether motor or

intellectual, is often very difficult for this type of patient since he must constantly fight the barrage of stimuli confronting him, in order to concentrate. This patient must be treated in a relatively stimulus-free atmosphere so that he can focus his full attention on the task at hand.

Brain-damaged patients are sometimes unable to read because they cannot group letters, words, and phrases into meaningful symbols—everything attracts them at once. It is difficult for such people to understand diagrams and follow road maps. Sorting and filing are likewise troublesome, since these tasks require the person to focus on a specific object or idea. In addition, some patients with figure-ground discrimination problems easily become stimulus-bound, a form of perseveration, where once having focused on a specific idea or object, letter, or phrase, they are unable to proceed to the next one.

### Accurate Perception of Space

Accurate perception of space is often another stumbling block for the stroke patient. Researchers have found that in the brain-damaged, there is sometimes a distortion in the perception of verticality, which may be related to somesthetic imbalance.<sup>3, 6</sup> Such patients lean and fall to the affected side, not because of weakness, but because they incorrectly perceive the vertical. Other investigators have found that there may be a directional rotation of the entire subjective visual field. The importance of correct visual orientation in the maintenance of upright posture is well known. Certain brain-damaged patients also have disturbances in the perception of the median plane and tend to ambulate in an angle towards the affected side of their bodies.<sup>4</sup> It is no wonder that distorted perceptions of the visual field often affect balance and locomotion.

Many stroke patients manifest deficiencies in the more sophisticated area of being able to visualize motion. This type of dysfunction may seriously handicap a person in the performance of manipulative tasks. In the extreme, some patients are unable to learn proper transfer techniques in therapy because of poor space visualization. A seemingly elementary task like putting on a sweater can become almost impossible.

One puzzling aspect of brain damage which affects motor output is a consistent inability to cross the body midline. Patients with this type of problem will either avoid crossing the midline by changing hands to perform a task, or by moving their bodies from side to side. If they do try to perform an act which necessitates working at the body midline or crossing over, they might be clumsy. This fact may explain why so many patients have difficulty with such body midline tasks as buttoning and shoe-lace tying.

Other anomalies appear during extensive percep-



tual motor testing and are seen to have clinical significance. For example, inadequate depth perception may reveal itself in difficulty going up and down stairs and curbs, and in navigating around architectural barriers. Brain-damaged people often have distorted concepts of time. Ten minutes may seem like an hour, or like several seconds. These people may arrive very early or very late for appointments because they cannot gauge time accurately. Distortions in the perception of temporal relationships can hamper learning ability. Assimilating tasks composed of several steps can be difficult for the patient because he does not understand the relationship between sequences of motor acts. In the therapy situation, series of exercises must often be broken down into the component parts, learned in isolated fashion, and then synthesized into a related whole.

### Deficiencies in Perception

Deficiencies in the perception of static spatial relationships are closely associated with motor planning, the third area of perceptual-motor dysfunction. Although a person may perceive correctly, he may not be able to translate his perceptions into effective motor acts.<sup>5</sup>

Problems in the perception of spatial relationships and their translation into motor acts can prove to be a serious handicap. Learning manipulative tasks of any type is often difficult. Homemaking for the one-handed stroke patient can prove to be more trying than one would expect, because what is actually required is the learning of new motor skills involving object visualization and manipulation. Problems in spatial orientation and duplication also invade the realm of reading and writing for patients who have either right or left hemisphere damage. The letter "b" may be read or written as "d" or the letter "p" as "q". Numbers may be written backwards. Driving safety is another area which could be severely affected by perceptual motor dysfunction, either because of figure-ground problems and consequent "distractibility", or because of poor space perception and faulty motor output.

### Conclusion

In summary, the chain of events in the perceptual motor process, so vital to relearning and retraining after stroke, includes the preparation of the individual, selection and integration of stimuli, and motor output. A final segment, interpretation, holds perhaps the widest significance for rehabilitation through motor learning. Every day, we judge our own performance, evaluating the details of the quality of our actions. Through our interpretation of results we are able to perceive success or failure. Most importantly, we are able to generalize so that each learning experience is not isolated but relates to previous-

ly learned material. Unfortunately, many stroke patients do not react to experience in this fashion. Instead of accumulating a reservoir of knowledge from their actions, instead of acquiring proficiency through generalization, they tend to react to each perception as something totally new. The barrier that this presents to retraining may be at times unsurmountable.

At this stage in our evaluative procedures, we are not always able to predict success or failure. We must, however, understand the components of success, in order that we may set realistic goals, achieve maximum results from treatment, and effectively evaluate our efforts.

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# Call it what you will, it may be premalignant.

## Before

3/29/67 Before therapy with 5%-FU cream. Patient P. T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

## After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.





# and Efudex® (fluorouracil) 5% cream can resolve it.

Call it actinic, solar or senile keratoses,  
many regard it as "precancerous."<sup>1,2</sup>

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,<sup>3,4</sup> offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these multiple lesions.

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Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.<sup>5</sup> Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.<sup>6</sup>

## Treats the lesions you can't see, too.

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## How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

## Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppurative scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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**References:** 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T. and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis*, 6:293, 1970. 4. Sams, W. M.: *Arch. Derm.*, 97:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer*, 25:450, 1970.



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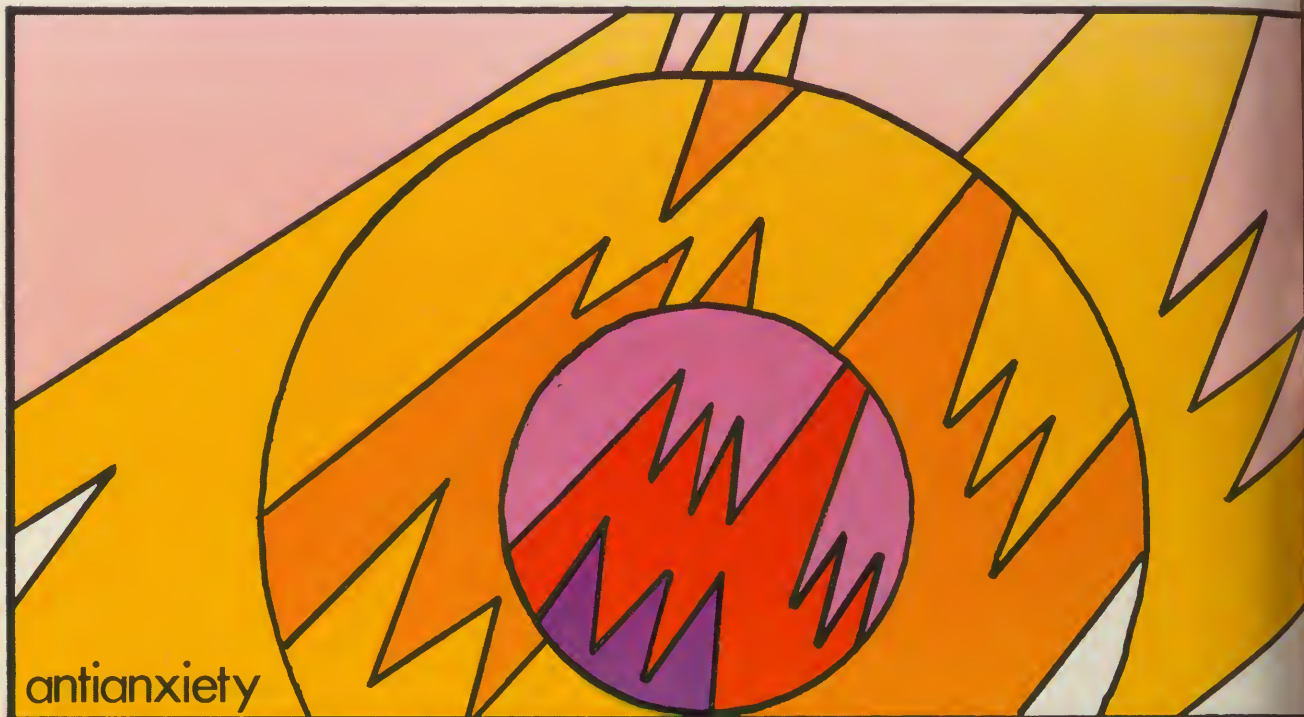




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chinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impend-

ing depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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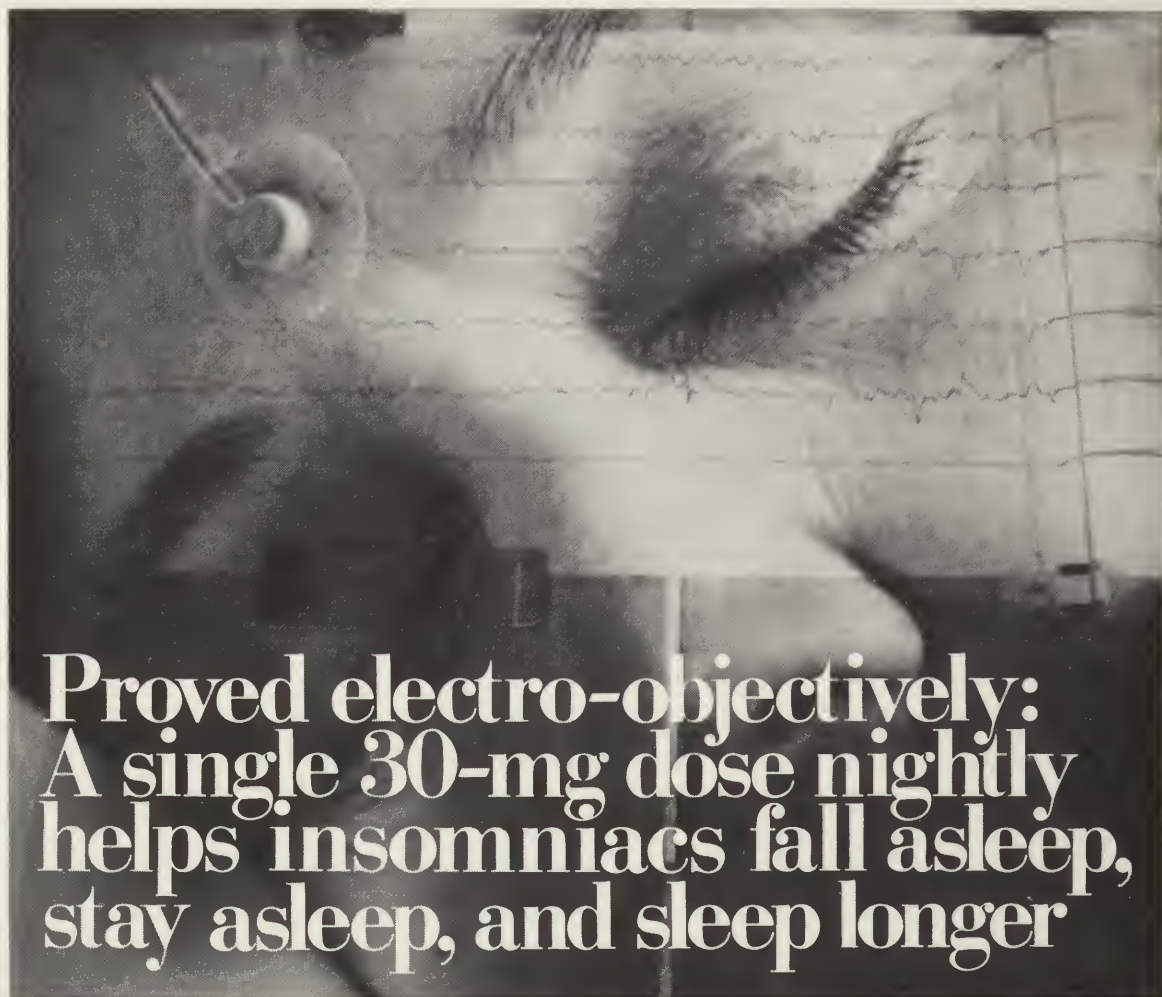
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Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,<sup>1</sup> Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

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## Confirmed clinically

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Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.



In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

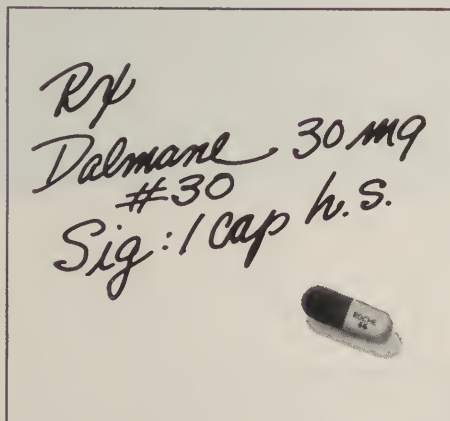
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### Dalmane (flurazepam HCl) is generally well tolerated

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In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.<sup>3</sup> Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

**References:** 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

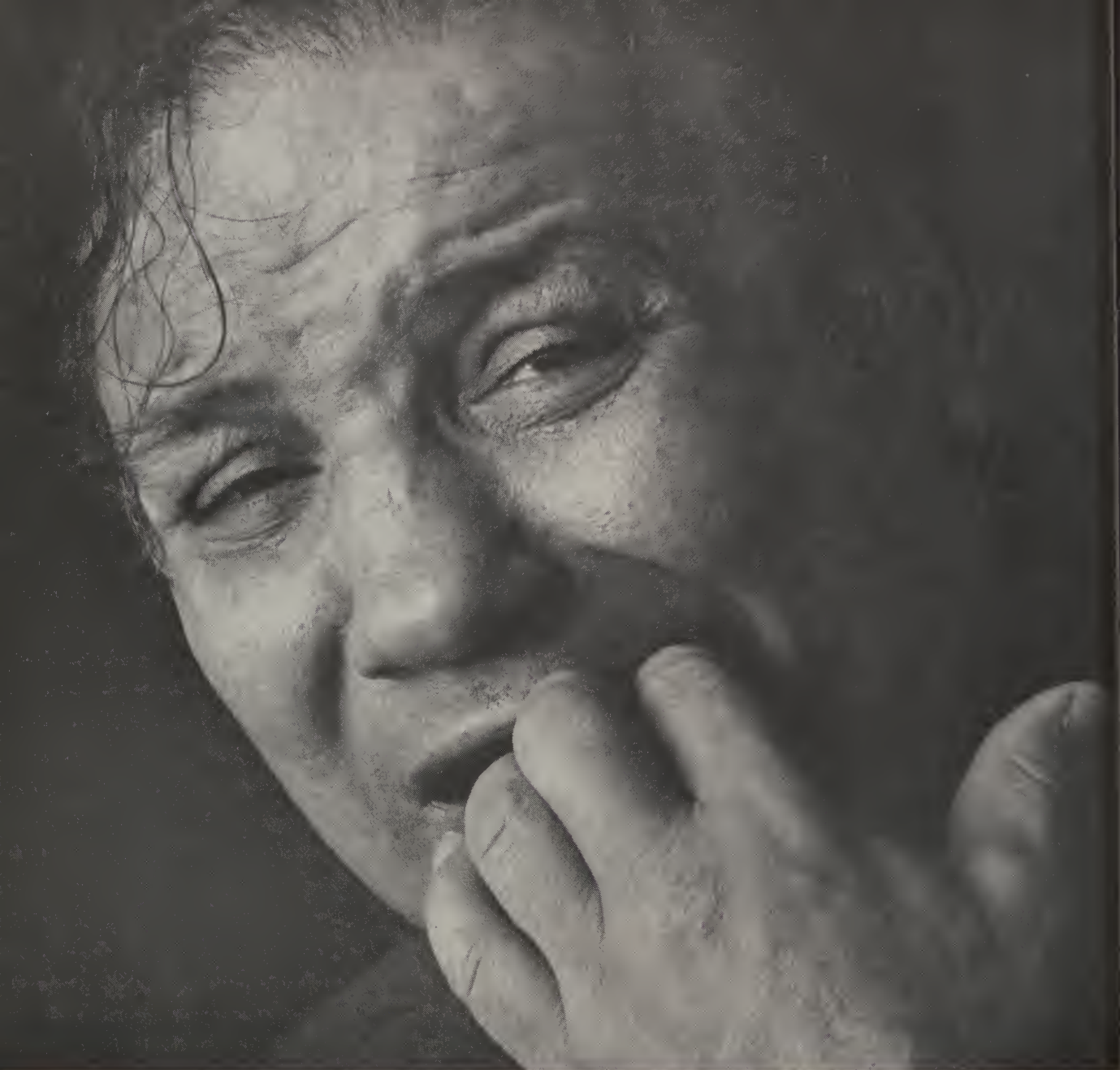
**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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"This article deals with the conduct of a surgical operation in which much thought is given to the prevention of sequelae to that operation, which sequelae may lead to a more prolonged acute morbidity, a further operation, or death of the patient. According to my predecessor at the University of Maryland, Dr. Arthur Shipley, there are three obvious Rules for the Surgeon: 1) To have a live patient, 2) not to leave the patient with something worse than the disease he presently has, and 3) to produce no new disease."

### Task Performance and Task Delegation in General Practice: Implications for Training of Physician's Assistants, William L. Stewart, MD, George Entwisle, MD . . . . . 67

"In recent years, there has been an increasing number of reports on the need for and use of trained physician's assistants. It has been estimated that their use increases physician productivity some 30% to 50%. Several institutions are now training assistants who would be capable of performing a variety of tasks and procedures as well as assuming clinical responsibilities. We have been considering the development of a training program for physician's assistants who would be working with Maryland general practitioners. We feel that the training program should be relevant to the current activities of the physician's office practice and to those tasks he would delegate to the trained assistant."

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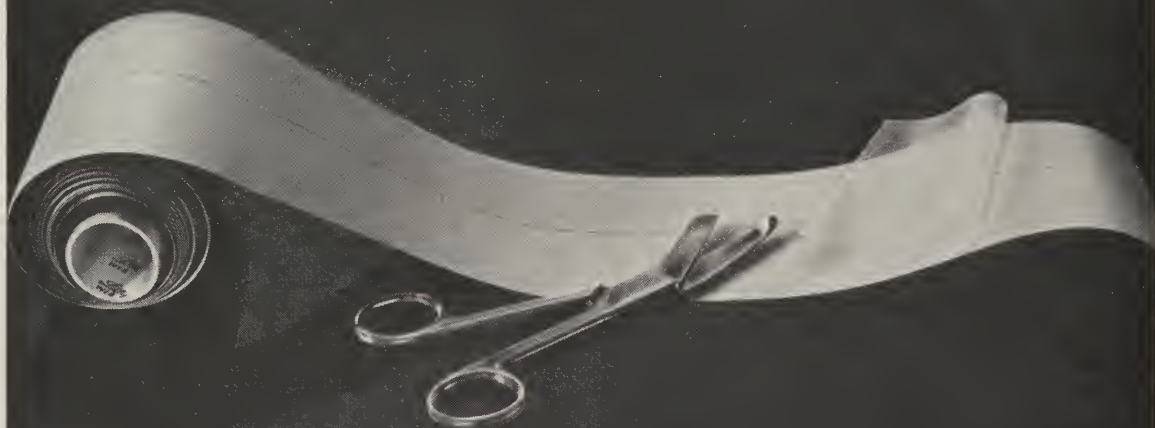


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# Doctors take note...

**AUGUST 21-28, 1971**

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**AUGUST 23-26, 1971**

## **AMERICAN HOSPITAL ASSOCIATION**

73rd Annual Convention: McCormick Place, Chicago, Illinois. Speakers include: Elliot L. Richardson, Secretary of Health, Education, and Welfare, and Peg Bracken, author of the *I Hate to Cook Book*. Instructional sessions will address such problems as consumer involvement in comprehensive health planning, attracting minority groups to top jobs, drug and alcohol abuse, emergency services and changing concepts of physician education. For information, write: Millard E. Krebs, 840 Lake Shore Drive, Chicago, Illinois 60611.

**AUGUST 29-30, 1971**

## **AMERICAN MEDICAL ASSOCIATION**

31st Annual Congress on Occupational Health: Jackson Lake Lodge, Grand Teton National Park, Wyoming. The program includes: Aerospace Symposium, Mental Health Symposium, Mining Symposium, Physical Fitness Symposium, and a Symposium on Rural Health. Among the speakers will be: E. F. Knipling, PhD, Director of Entomology Research Division, Agricultural Research Service, U.S. Department of Agriculture, Beltsville, Maryland; Donald J. Morrison, MD, Northern Wyoming Mental Health Center, Sheridan, Wyoming; Griffith E. Quinby, MD, Consulting Toxicologist, Wenatchee, Washington. For further information, write: American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

**AUGUST 29-SEPTEMBER 3, 1971**

## **UNIVERSITY OF GLASGOW**

International Embryological Conference: Glasgow, Scotland. Contact: Professor A. S. G. Cutis, Department of Cell Biology, University of Glasgow, Glasgow W2 United Kingdom.

**SEPTEMBER 6-11, 1971**

## **INTERNATIONAL CONGRESS OF HUMAN GENETICS**

International Congress of Human Genetics: Paris, France. Contact: J. deGrouchy, MD, Hospital des Enfants Malades, 149 rue de Sevres, Paris 15e, France.

**SEPTEMBER 9-11, 1971**

## **AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS**

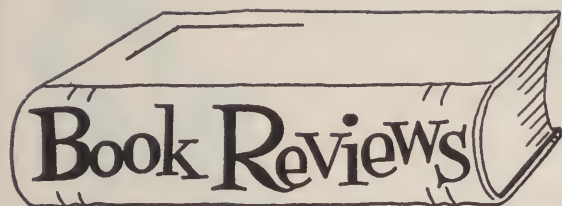
Conference: Hot Springs, Virginia. Contact: Charles A. Hunter, MD, Indiana University Medical Center, 100 W. Michigan Street, Indianapolis, Indiana 46202.

(Continued on page 12)









**A TEXTBOOK FOR MEDICAL ASSISTANTS, M. Murray Lawton, MD, and Donald F. Foy, MPH; The C. V. Mosby Company, St. Louis, Missouri, 1971.**

The authors state in the preface that it "... is our intent to provide the most comprehensive work on the training of medical assistants up to the present, while not sacrificing lucidity and practical application." While it has not been possible to read this book in depth, it certainly presents a variety of subjects, and a brief examination of the content reveals that it indeed does what the authors intend.

The contents range from basic information which identifies the various medical specialties and symbols, through the performance of various paramedical procedures.

This seems to be the most comprehensive book that has ever been devoted to this subject. It is one that every physician should own—newly employed secretaries or office assistants could benefit greatly from reading its chapters on subjects in which they may be either ignorant or deficient. In addition, it would make an excellent reference work for all girls Friday who work for physicians. We would strongly recommend its purchase for this purpose alone.

**SPEECH PATHOLOGY, William H. Perkins, PhD; The C. V. Mosby Company, St. Louis, Missouri, 1971.**

This is probably the first basic text to be written in this field. Divided into two sections—the first on "conceptual underpinnings" from which speech pathologists draw applications—it is an excellent book for all those interested.

The second section deals with applications of speech pathology, and this it does extremely well.

If any person wishes to relate one thing to another in this area of practice, he would do well to purchase a copy of this text.

**GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, the American Medical Association Committee on Rating of Mental and Physical Impairment, 1971.**

Fifteen years ago, this AMA committee was directed to establish a series of practical guides for the evaluation of physical impairment of the various body systems. In 1963, its scope was enlarged to include mental impairment. This book is a compilation of the separate papers published in *JAMA* over the years, and which have been available as separate reprints during that period of time.

This single volume brings them all together, and incorporates many changes that have occurred since publication of the first papers.

For those physicians who have an interest in this area, this publication is well worthwhile adding to their libraries.

**SYNOPSIS OF PEDIATRICS, third edition, James G. Hughes, MD, The C. V. Mosby Company, St. Louis, Missouri, 1971.**

This marks the third edition of this publication in four years, indicating the speed with which changes occur in the area of pediatric medicine. New chapters have been added and others blended together; however, it still remains a sizable publication.

We are sure that this book does what the author suggests, in stating "... our synopsis will continue to serve a useful purpose in encouraging interest in and knowledge of pediatrics."

**PHYSIOLOGY OF REPRODUCTION, William D. Odell, MD, and Dean L. Moyer, MD; The C. V. Mosby Company, St. Louis, Missouri, 1971.**

This book offers current concepts of basic reproductive processes in the human. It is not intended as a text on clinical medicine or pathology, and no reference to important disease states is included.

Reproductive processes are traced first through a "static view" of the systems involved and then second, through a "dynamic view".

The authors state, "... it is our hope that this text will serve to prepare a solid base from which the budding reproductive physiologist can launch himself into an investigative career." This it does well.



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PROFESSIONAL  
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Physicians are reminded that the professional corporation laws prohibits the use of any corporate name unless approval of the Faculty and the Board of Medical Examiners is obtained. The law also requires that such professional corporations have five or more physicians as members.

In cases where there are less than five physicians in a professional corporation, the name of one or more of the physicians must be included in the title, followed only by the words, "Chartered", "Professional Association", or "P.A".

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It is advised that the state identification number for drugs need not be shown on the physician's Rx blank. All pharmacies throughout the state have been so notified.

At present, the Faculty is working toward eliminating the duplicate registration now required. Full details will be provided when concrete decisions have been reached.

REPORTS  
AND  
RESOLUTIONS

No resolutions have been received for consideration at the Semiannual Session. Committee reports containing recommendations have been mailed to all delegates as well as officers of component societies. Copies may be obtained at the Faculty office.

PHYSICAL  
FITNESS  
SYMPOSIUM

A symposium on Exercises and the Heart is scheduled for Monday, November 8, from 2 PM to 5 PM at the Host Farm Resort Hotel in Lancaster, Pa.

Interested persons should contact the Faculty office for further details.

  
Executive Director



# executive director's newsletter

August 1971

## NEW PUBLICATIONS

A revised copy of the booklet Laws, Rules and Regulations With Which Physicians Must Comply will be available in the near future. Corrected through July 1, 1971, the booklet includes all state laws, as well as policy decisions reached by the Faculty over the years.

Also available is a newly revised version of the Compendium of Decisions...dealing with ethics, propriety and legality governing the practice of medicine in Maryland, originally published in July 1970. The new version has been updated through July 1971.

Copies may be obtained through the Faculty office at 1211 Cathedral St., Baltimore, Md. 21201, telephone 539-0872.

## SEMIANNUAL SESSION

The Semiannual Business Session will be held on Saturday, September 11, at the Faculty building. The Executive Committee is scheduled to meet at 9 AM, followed by the Council at 11 AM.

The House of Delegates will meet at 2 PM.

The Semiannual Scientific Sessions will be held in Puerto Rico from September 15-19. Details on the Puerto Rico trip can be obtained from the Faculty office.

## ANNUAL MEETING

At the Faculty's Annual Session held in May, a record number of physicians and an overall total number of those attending was recorded. Almost 25% of the total membership attended the meeting; and this figure was further increased by residents, interns, medical students, nurses, and other related professionals.

## 1972 CAR MODELS

1972 new car models are available to Faculty members under the newly developed car leasing program. Full details may be obtained by contacting:

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## Doctors Take Note . . .

*(Continued from page 5)*

### **SEPTEMBER 13-15, 1971 AMERICAN EEG SOCIETY**

Continuing Education Course—Clinical Electroencephalography: Minneapolis, Minnesota. The course is designed to review the principal applications of the EEG to clinical medical practice. For information, write: Donald W. Klass, MD, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901.

### **SEPTEMBER 13-15, 1971 COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY AT NEWARK**

International Conference on Student Drug Abuse: Newark, New Jersey. The conference will explore the following issues: Why initiate a survey? drug surveys and the press, implementation of surveys, confidentiality and surveys, the survey: whose responsibility? and social implications. For information, write: Armund E. Foley, Director of Communications, College of Medicine and Dentistry of New Jersey at Newark, 100 Bergen Street, Newark, New Jersey 07103.

### **SEPTEMBER 14-18, 1971 AMERICAN ASSOCIATION OF MEDICAL CLINICS**

22nd Annual Meeting: Sheraton-Cleveland Hotel, Cleveland, Ohio. Prepaid medical care, health maintenance organizations, financing of health services, and training and use of allied health personnel will be the featured topics. Problem-solving workshops will cover such problems as clinic quality control, cost effectiveness, multiphasic screening, physician recruitment, computer use in clinics, satellite clinics, education programs, and income distribution. Contact: AAMC, 719 Prince St., Alexandria, Virginia 22313.

### **SEPTEMBER 18 AND 25, 1971 COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY**

Continuing Education Course—The Shoulder: A Course in Depth: College of Medicine and Dentistry of New Jersey, Newark, New Jersey. The course will deal with disorders of the shoulder. For further information, call Armund E. Foley, Director of Communications, at 201-877-4560.

### **SEPTEMBER 20-24, 1971 AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**

Annual Meeting: Convention Center, Las Vegas, Nevada. For further information, write: C. M. Kos, MD, Executive Secretary Treasurer, American Academy of Ophthalmology and Otolaryngology, 15 Second Street SW, Rochester, Minnesota, 55901.

### **OCTOBER 13-15, 1971 DEPARTMENT OF DERMATOLOGY, NEW YORK UNIVERSITY SCHOOL OF MEDICINE**

Symposium—Allergic Eczematous Contact Sensitization: Alumni Hall, New York University Medical Center, 550 First Ave., New York city. Merrill W. Chase, MD, will speak on "The Mechanism of Contact Allergy and the Concept of Peripheral Sensitization." For further information, write: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N. Y. 10016.

### **OCTOBER 30, 1971 MARYLAND-D. C. SOCIETY OF ANESTHESIOLOGISTS**

Symposium—Respiratory Insufficiency: Friendship International Hotel, Friendship Airport, Baltimore, Maryland. Clinical discussions of great current interest will include oxygen toxicity, postoperative pulmonary edema, lung mechanics, and respiratory failure. The registration fee is \$20, and includes lunch. Contact: Gerald J. Carroll, 5813 Meadowood Road, Baltimore, Md. 21212.



# Baltimore County Medical Association

The regular meeting of the Baltimore County Medical Association was held at St. Agnes Hospital on Wednesday, June 15 at 1 PM.

The meeting was called to order by John Krager, MD, president, who expressed appreciation to St. Agnes for inviting the Association.

Dr. Krager then introduced and welcomed the following new members: Doctors Kyung Ho, John DeCarlo, Marianne Benkert, Kay Cutler, Oscar Villacrusis, and D. Piroviolodis.

The Board of Governors of the Baltimore County Medical Association decided that interns and residents would be invited to become associate members of the Association.

The Board of Governors also approved establishing a Peer Review Committee which would be concerned with physicians who practice within the confines of Baltimore County.

A motion to approve the resolution on peer review was seconded and unanimously carried by the members of the Association.

The following applications for membership were approved: Doctors DeChamma Alexander, Henry Babitt, Newland Day, Edward Featherstone, Anthony Stedem, and Robert Tancredi.

Mr. John Sargeant, Executive Director of the Medical and Chirurgical Faculty, then reported on some of the cases that have been referred to the Peer Review Committee of the Faculty.

According to the guidelines of the Faculty's Peer Review Committee, the major thrust of peer review is to evaluate the quality of care to the patient.

There being no further business, the meeting was adjourned.

Alfred E. Iwantsch, MD  
Journal Representative

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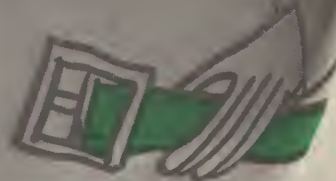
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and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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# MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

## Report\*

*Mr. President and Members of the House of Delegates:*

I would like to express my appreciation to the MMPAC Board members, whose guidance, advice, encouragement, and attendance at the many meetings have made my duties as Chairman much easier. To the Board members, I say THANK YOU:

William A. Andersen, MD, *Secretary*  
Fred N. Cole, Jr., MD, *Treasurer*  
DeWitt E. DeLawter, MD  
George G. Finney, Jr., MD  
William R. Greco, MD  
Joseph H. Hooper, Jr., MD, *Vice-Chairman*  
Raymond L. Markley, MD, Editor, NEWS-LETTER

Mrs. Karl F. Mech, *Assistant Treasurer*  
Howard Moses, MD  
Neil Novin, MD  
William P. Sadler, MD  
Robert J. Thomas, MD

I would also like to thank Mr. John Sargeant and his staff at the Faculty who have been most cooperative and helpful.

Every congressional district is presently represented on the Board and each area has a chairman who is a Board member. In this way we are organized for political action and education in each district.

Between April 1970 and May 1971, the Board met at least eight times, not including the many telephone conferences or the meetings at the homes of our Board members.

During an election year, candidates are invited to meet with the Board or Executive Committee. This is a time-consuming process but it is important, as it makes the candidates aware of the medical profession and alerts them to the fact that we are always available to answer their questions, make suggestions, or give advice concerning pending legislation; and what we as physicians believe is in the public good. We talked with 25 candidates from both major parties and supported those whom we thought would represent our viewpoints. The NEWS-LETTER, under the editorship of Raymond L.

Markley, MD, provided information about the candidates and, it is hoped, assisted you in making your decision when you went to the polls.

A representative group of members attended the AMA-AMPAC Public Affairs Workshop in Washington, D. C., on March 13 and 14, 1971. AMPAC members attended from 49 states, the District of Columbia, and the Virgin Islands. Such representation indicates the tremendous growth at the national level and also the increasing interest by the medical profession in federal legislation. We congratulate the AMPAC Board of Directors, Mr. William Watson, the Executive Director of AMPAC, and his staff for arranging an excellent educational program and carrying it out so efficiently.

During the Semiannual Meeting of the Medical and Chirurgical Faculty at the Hotel Hershey in Hershey, Pennsylvania, we had a breakfast meeting in the Main Dining Room on Saturday, September 12, 1970. A large audience heard the Honorable J. Glenn Beall, Jr., who at that time was a member of the House of Representatives but is now in the U.S. Senate. Mr. Beall's address was informal and he ably and graciously answered questions from the floor asked by the physicians and their wives.

The Annual Meeting Luncheon was held at the Civic Center in Baltimore on May 12, 1971. Following the election of officers for 1971-1973, Mr. Chad Combs, Assistant Director of the AMA Department of Field Service and Staff Liaison for the American Political Action Committee, gave an enlightening address on The AMA's Medcredit Proposal. Mr. Combs, our liaison representative, is knowledgeable in the AMA and AMPAC activities and always seems to have time to advise the Board and he is always available to attend our meetings. We are most appreciative of the assistance given to MMPAC by Mr. Combs.

A copy of the remarks of Mr. Combs on the medcredit proposal of the AMA is included at the end of this report and I hope all will take time to read them. It is most important that we physicians acquaint ourselves with medical legislation before Congress so that our influence can be felt.

The officers who were elected in May 1971 are:

*Chairman*—DeWitt E. DeLawter, MD, Bethesda

*\*Annual Report to the House of Delegates of the Medical and Chirurgical Faculty, May 12, 1971—Transactions.*



*Vice-Chairman*—Raymond L. Markley, MD,  
Baltimore

*Secretary*—William A. Andersen, MD, Luther-  
ville

*Treasurer*—Fred N. Cole, Jr., MD, Baltimore

Congratulations to these officers and my best wishes for a successful two-year tenure of office. May MMPAC increase in membership, in its pro-

gram, and in its value to the medical profession in Maryland. This can only be accomplished through the efforts of every member. I urge you to join them, to support them, and above all to BE SURE TO VOTE.

Respectfully submitted,

George G. Finney, Jr., MD

*Chairman, MMPAC, April 1969 to May 12, 1971*

## AMA's Medcredit Proposal

**Remarks of Mr. Chad Combs at the Annual Meeting of the Maryland Medical Political Action Committee, Civil Center, Baltimore, Maryland, Wednesday, May 12, 1971**

Mr. Chad Combs, Assistant Director of the AMA Department of Field Service and staff liaison for the American Medical Political Action Committee, delivered an address on the AMA's Medcredit proposal on May 12, 1971.

Mr. Combs pointed out that the AMA's bill for alleviating portions of the health care problems facing the country now has nearly 140 co-sponsors in the Senate and House. He suggested that the massive support that has been generated for the bill at the present time is in part due to the increased participation in the political arena through the PAC movement. The AMA's bill has more co-sponsors than any other single national health insurance proposal presently before the Congress. This includes the so-called Kennedy bill, with about 110 sponsors.

The AMA's bill has been co-sponsored by Senator J. Glenn Beall of Maryland and Congressmen Goodloe Byron and Lawrence Hogan. Several other legislators supported by MMPAC in the past in addition to these two are presently giving serious consideration to co-sponsorship.

Mr. Combs said that it is established AMA policy that it is "a basic right of every citizen to have available to him high quality medical and health care". The AMA also believes that where there presently exists economic barriers that prevent a significant segment of our population from sharing in the overall national affluence and impressive advances made in business and industry, science, education, social welfare, and other elements of American life, these barriers should be removed through legislation. This is the intent of AMA's Medcredit bill.

Medcredit is a program to give every person in America under the age of 65 equal access to high quality medical and health care regardless of ability to pay. Without disturbing the present Medicare program for the elderly, but replacing Medicaid for

the poor and near poor, the AMA's bill would make available to everyone under 65 a private program of comprehensive medical and health care protection covering both the ordinary and catastrophic expenses of illness or accident.

The AMA's bill provides that the poor would receive a voucher from the federal government which the individual could then exchange for a private insurance policy written with basic coverage from the company of his choice. This policy would include basic care for inpatient and outpatient services including preventive, diagnostic or therapeutic services in hospital, extended care facility, the physician's office, the patient's home or elsewhere. The policy would also include a section covering catastrophic or extended illness.

Those who do not fall into the designated category of the "poor" would receive credit on their federal income tax liability for the purchase of the basic health insurance policy from a private company and the catastrophic coverage in addition. Based upon one's federal tax liability in a given year this would allow federal participation in assisting with payment for health insurance coverage for all Americans. This would be based on a sliding scale with those being near poor having most of their premium paid for through credits on their federal income tax liability and those who are in the modest income category receiving lesser amounts toward payment of their premium. Those at the upper end of the scale would have little or no federal participation.

Mr. Combs pointed out that the AMA's approach to the problem would recognize degrees of need for American families in a particular year. These needs are fairly accurately reflected in one's income tax liability. It would also recognize that the federal government should assist those who need the most help first and that the degree of assistance should



be flexible so that those who can adequately take care of their own cost of private health insurance should be expected to do so.

The catastrophic coverage participation would also be based upon this sliding scale principle.

The AMA's bill provides for modest deductibles in an effort to control patient utilization.

Mr. Combs said that the details of the AMA's proposal are contained in a pamphlet, *Medical and Health Care for All*, available from the AMA Regional Office, 1300 Market Street, Lemoyne, Pennsylvania 17043. He urged that every physician and physician's wife become familiar with the general approach as well as some of the specific provisions of the AMA's proposal in order that they can begin education of community leaders and others as the debate on national health legislation heats up in the next year or two.

It was pointed out that the present AMA bill in all probability will not be the exact bill finally adopted by the United States Congress. However,

with the large number of co-sponsors to this legislation and the fact that AMA's bill was the first in the legislative hopper does mean that the physician population will have significant input into legislation that will be prepared for final adoption by the Congress.

Mr. Combs pointed out that national health legislation may very well be a primary campaign issue in 1972 and that it is imperative that physicians continue and expand their support of the PAC movement if the medical community is to continue toward a significant influence on matters of national health legislation.

Mr. Combs indicated that the AMA's bill would cost in the neighborhood of \$15 million as compared to some of the other proposals that would cost as much as \$80 million and that it would capitalize on the best elements of the present health care system while providing for innovative programs without destroying all that we have presently and substitute for it an untried system of health care.

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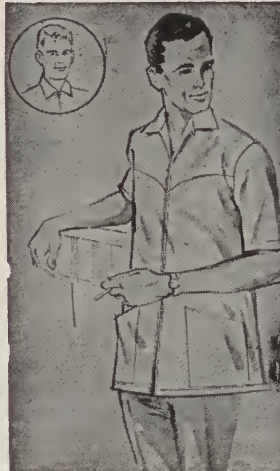
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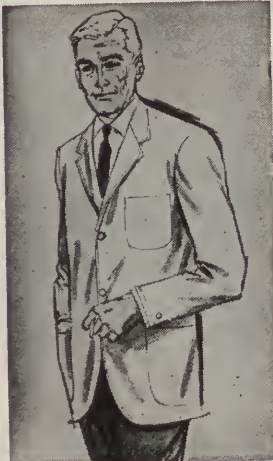


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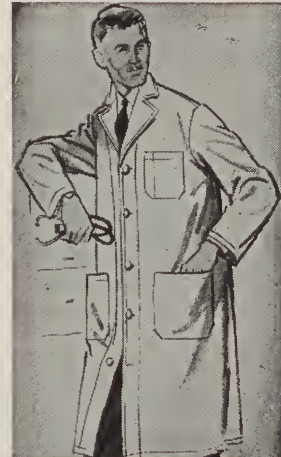
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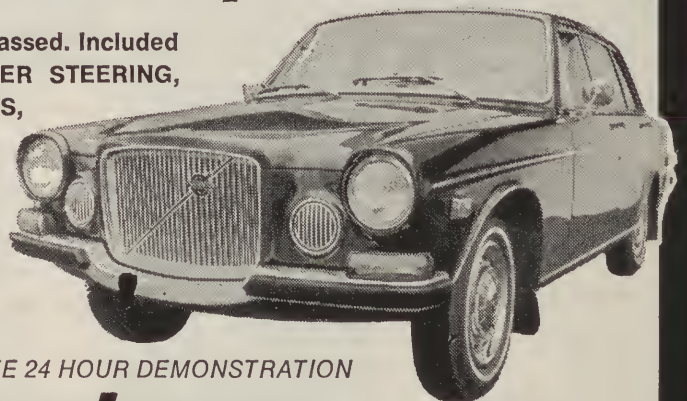
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## Robinul® 2mg. Forte (glycopyrrolate)

**INDICATIONS** Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 2 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

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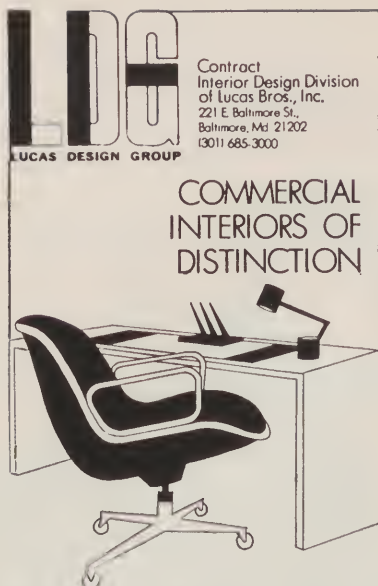
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Epilepsy is the concern of

every American. It is America's concern because epilepsy affects more Americans than cancer, tuberculosis, cerebral palsy, muscular dystrophy, and multiple sclerosis combined.

It is America's concern because for every one of the 4,000,000 million Americans with epilepsy, approximately three others are affected.

It is America's concern because no one is immune to epilepsy.

It is America's concern because medically epilepsy is among our most neglected health problems. The National Health Education Committee estimates that fewer than half of the epilepsy patients in this country are receiving adequate medical care.

*National News*

Epilepsy Foundation of America

## She Knows More

The average American wife—housewife or business woman—knows more about her family's health insurance benefits than her husband. And that, according to a U.S. Public Health Service survey, holds true in every age bracket.

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... that warming a cow's water supply in the winter improves milk production?

... that one out of every six workers in the retail trades is employed by the food service industry?



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# American Association of Medical Assistants

May 15, 1971 was the date of a very successful state meeting of the association at the Penn Hotel in Towson. Raymond Atkins, MD, State Advisor, gave the welcoming address.

Mrs. Nell Chaney, Editor of the state bulletin, *The Banner*, received a beautiful editorial award from the AAMA at the national convention. All the Maryland members are extremely proud of Mrs. Chaney for this achievement.

Mr. Frederick Schmuff of the Department of Juvenile Service of Baltimore County spoke on the current problems of juvenile delinquency. "Delinquent to Criminal or Citizen" was the topic. Mr. Schmuff also had a detailed display of narcotics on loan from the sheriff's office, that have actually been confiscated from juveniles.

Russell Fisher, MD, had a special report on the Kennedy assassination which proved most revealing. Dr. Fisher also showed some fascinating slides with his talk.

\* \* \*

Representing the state of Maryland at the coming annual convention of the AAMA in Georgia will be:

Delegates: Mary Minnick—Cumberland

Nell Chaney—Baltimore

Jean Subock—Anne Arundel County

Alternate Delegates: Gertrude Gillum—Cumberland

land

Dorothy Walker—Baltimore

Mabel Young—Cumberland

\* \* \*

Henry Wollenweber, MD, was elected as Advisor to AAMA—Maryland. Dr. Wollenweber has recently served two terms as Advisor to the Baltimore Chapter and has been very instrumental in the educational programs.

## Baltimore Chapter

The Baltimore Chapter sponsored Mr. Jack Webb in the Walk-A-Thon for the March of Dimes. Mr. Webb walked 20½ miles. The medical assistants were very proud to sponsor such a hero.

Mr. Paul Ayd, CPA, taught a course in accounting at the Baltimore Institute especially for the medical assistants for the purpose of certification.

The annual Bosses' Night was held at Overlea Hall with entertainment by the medical assistants. Alfred Cole, MD, was on hand to take movies of the gala festivities and also to show movies of past Boss Nights. An outstanding event of the evening was the presentation of the Medical Assistant of the Year Award for Baltimore. This was received by Dorothy Hartel. This was the first time such an award has been presented.

## Anne Arundel Chapter

At the January meeting, Sgt. Frank Mazzone of the Maryland State Police Narcotic Squad spoke on the prevention of the use of drugs. In February, Mr. Charles Bowie of the Wyeth Company showed films pertaining to the prevention of malpractice suits against physicians and medical assistants. In April, Dr. Palmer spoke on breast cancer.

## Wicomico Chapter

In March, Earl Royer, MD, was the guest speaker. In April, Harold Eccleston, MD, discussed inhalation therapy at the Peninsula General Hospital School of Nursing. In May, Mr. John Webb of Maryland Blue Shield, Inc. was the guest speaker.

\* \* \*

SEPTEMBER 11, 1971—DATE OF THE SEMIANNUAL MEETING

PLACE—Sandpiper, Ocean City, Maryland

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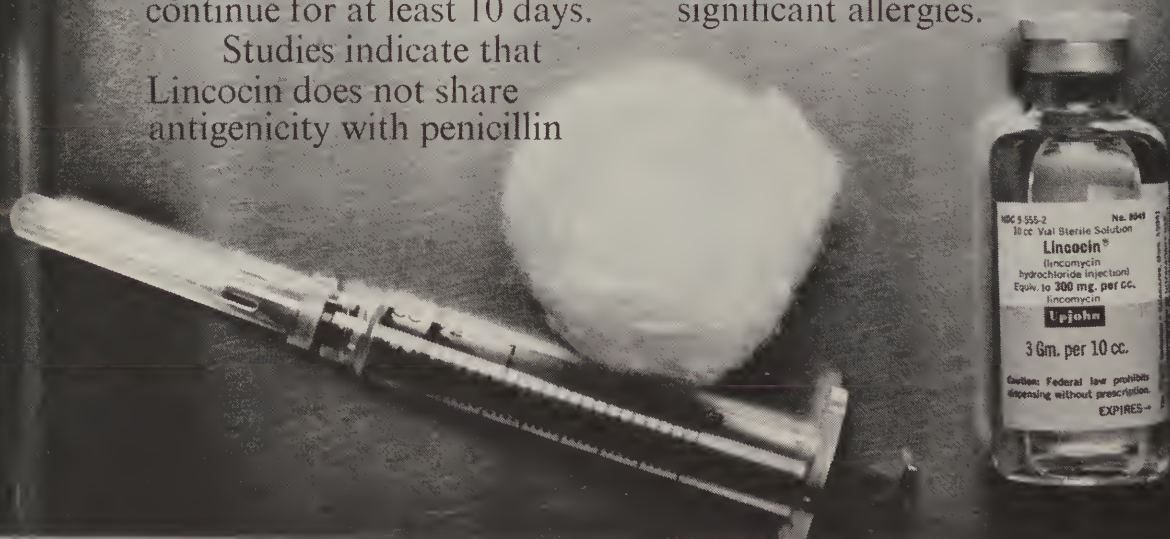


# Hypersensitivity to penicillin is a good reason to consider Lincocin® (lincomycin hydrochloride)

Lincocin (lincomycin hydrochloride, Upjohn) has produced a high percentage of satisfactory responses in patients with mild, moderate and severe infections due to susceptible streptococci, pneumococci and staphylococci (including many penicillinase-producing strains). With  $\beta$ -hemolytic streptococcal infections, treatment should continue for at least 10 days.

Studies indicate that Lincocin does not share antigenicity with penicillin

compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.





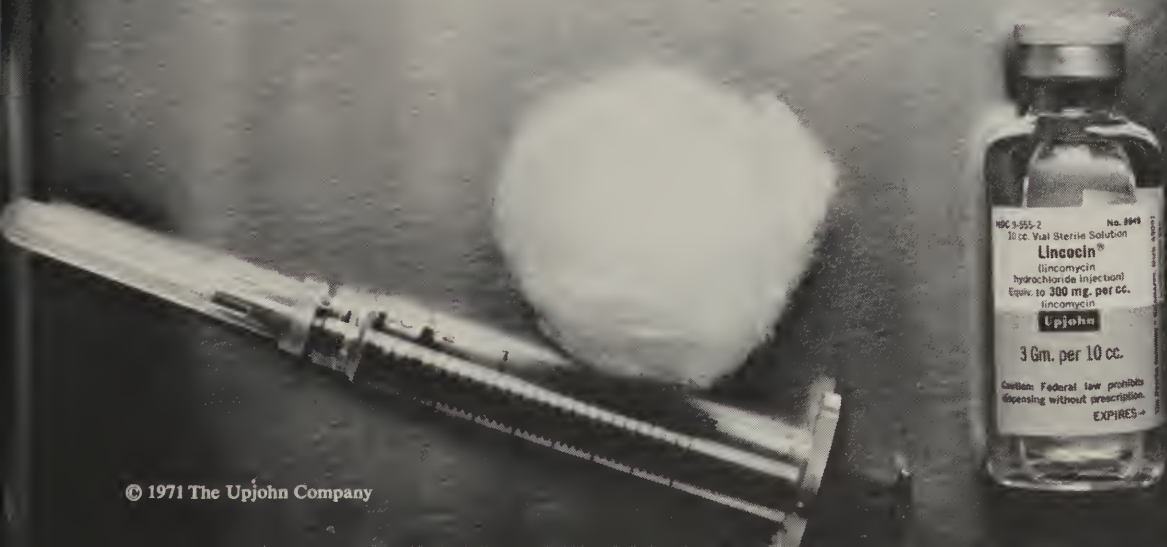
# So is penicillin-resistant staph.

Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with

all antibiotics, susceptibility studies should be performed.

Intramuscular and intravenous injections of Lincocin (lincomycin hydrochloride, Upjohn) are generally well tolerated. Instances of hypotension following parenteral administration have been reported, particularly after too rapid intravenous administration.

Sterile Solution (300 mg. per ml.)  
**Lincocin<sup>®</sup>**  
(lincomycin hydrochloride,  
Upjohn)





Sterile Solution (300 mg. per ml.)

# Lincocin<sup>®</sup>

(lincomycin hydrochloride, Upjohn)  
for respiratory tract, skin, soft-tissue, and  
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Each preparation contains: Lincomycin hydrochloride monohydrate equivalent to lincomycin base

250 mg. Pediatric Capsule . . . . . 250 mg.  
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\*Sterile Solution per 1 ml. . . . . 300 mg.  
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\*Contains also: Benzyl Alcohol 9 mg.; and, Water for Injection—q.s.

An antibiotic chemically distinct from others available, indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed.

**CONTRAINDICATIONS:** History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or

significant allergies. Overgrowth of non-susceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angio-neurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.

**Cardiovascular**—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. **Local reactions**—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg. and 500 mg. Capsules—bottles of 24 and 100.

*Sterile Solution, 300 mg. per ml.*—2 and 10 ml. vials and 2 ml. syringe.

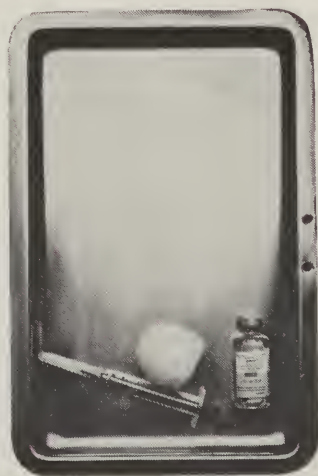
*Syrup, 250 mg. per 5 ml.*—60 ml. and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

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**Donato Joseph Alamprese, MD**, an attending staff psychiatrist at St. Agnes Hospital in Baltimore, has been elected president of the National Guild of Catholic Psychiatrists. In addition to being president and a founding member of the National Guild, Dr. Alamprese is a Fellow of both the American Psychiatric Association and the American Geriatrics Society. He holds membership in the World Medical Association, World Psychiatric Association, American Medical Association, Southern Medical Association, Association for Research in Nervous and Mental Disease, and the American Epilepsy Society. Locally, he is a member of the Medical and Chirurgical Faculty of the State of Maryland, the Maryland Psychiatric Society, and the Baltimore City Medical Society.



**Dr. Alamprese**

\* \* \*

The following physicians have been made Fellows of the American College of Physicians: From Baltimore: **Virginia Huffer, MD**, **J. O'Neal Humphries, MD**, **Chris Papadopoulos, MD**, **Nathaniel F. Pierce, MD**, and

## MEDICAL NEWS

**W. Gordon Walker, MD**; from Bethesda: **Phillip Gordon, MD**, **Harry Keiser, MD**, and **Paul H. Levine, MD**; and from Ellicott City: **Emile R. Mohler, Jr., MD**.

\* \* \*

**Francis Lambert**, Sheppard-Pratt's Hospital Administrator, has been appointed as the Association of Mental Health Administrator's representative in organizing the Commemorative Conference honoring the silver anniversary of the enactment of the National Mental Health Act (authorizing the formation of the National Institute of Mental Health).

\* \* \*

**Elihu E. Allinson, MD**, of Baltimore, was elected president of the Maryland Psychiatry Society at its annual business meeting. Dr. Allinson, a fellow of the American Psychiatric Association since 1962, has been Maryland's delegate to the American Psychiatric Association since 1967, and will continue in this role during his term of office. He has served terms as president of the Maryland Association of Private Practicing Psychiatrists, and of the visiting staff of the Seton Psychiatric Institute.

In addition to private practice in Baltimore, Dr. Allinson is an assistant professor in psychiatry at The Johns Hopkins Hospital and is chief of psychiatry at North Charles General Hospital. He also serves on the staff of Sinai Hospital.

\* \* \*

The **Burrough's Wellcome Fund** has announced the endowment of the Wellcome Professorship in Clinical Pharmacology

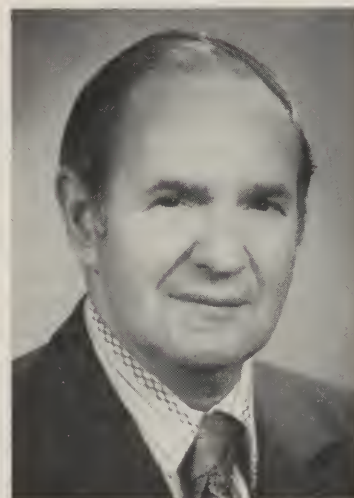
at The Johns Hopkins University School of Medicine. The fund has been a major impetus for the development of teaching, training, and research in clinical pharmacology.

\* \* \*

**Isadore Kaplan, MD**, Director of Medical Services for the Chesapeake and Ohio-Baltimore and Ohio Railroads, has been elected chairman of the Medical Section of the Association of American Railroads for the year 1971-1972.

The group is composed of surgeons and medical directors of all Class I railroads in the United States and Canada and is responsible for formulating medical policies governing the rail carriers.

Dr. Kaplan is a member of the American Medical Association, the Baltimore City Medical Society, and the Medical and Chirurgical Faculty.



**Dr. Kaplan**

\* \* \*

**Harry L. Knipp, MD**, and **John F. Schaefer, MD**, have recently been elected presidents



of medical organizations in Maryland. Both are residents of Ten Hills and have offices in the western sections of Baltimore and both are on the staff of Bon Secours Hospital. Dr. Knipp is also a member of the St. Agnes Hospital attending staff.

Dr. Knipp, a family practitioner, was installed as president of the Maryland Academy of General Practice at the organization's annual meeting in Lancaster, Pennsylvania. Dr. Schaefer was recently elected president of the Medical and Chirurgical Faculty of the State of Maryland at its annual meeting in May.

The Johns Hopkins University School of Medicine announced that it will name a research laboratory in honor of the late **Alan Bernstein, MD**, who was an associate professor of medicine at Hopkins and a leading internist in Baltimore.

The **Alan Bernstein Memorial Laboratory** will be devoted to research in clinical pharmacology, which is the study of how patients react to drugs. It is located on the fifth floor of The Johns Hopkins Hospital's Osler Building.

Dr. Bernstein, who died in 1969, was an expert in the field of clinical immunology and hematology, and was best known for his work on infectious mononucleosis.

**Leonard J. Gallant, MD**, of Baltimore, Associate Professor of Psychiatry at The Johns Hopkins Medical School, recently toured the South Pacific, attending medical seminars in New Zealand, Australia, and Tahiti. In addition to reviewing the psychiatric facilities in New Zealand and at Auckland General Hospital, he was asked to give seminars. He gave a joint seminar to both the Department of Psychiatry and the Depart-

ment of Dentistry at the University of New South Wales in Sydney, Australia.

**John C. Norton, Jr., MD**, was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting in San Francisco. Dr. Norton has been a member of the staff at Bon Secours Hospital since 1946 and served as president of the staff 1968-1969.

**Benjamin F. Hughes, MD**, assistant resident in urology at The Johns Hopkins University School of Medicine, has won for his research paper a financial boost from the Southern Medical Association in the form of a Research Project Fund Grant. The subject of Dr. Hughes' project is Evaluation of the CO<sub>2</sub> Laser for Urologic Surgery—Laser Vasectomy.

**Bert W. Schmickel**, an internationally known expert on mental retardation, has been appointed Director of Mental Retardation, according to an announcement made today by **Neil Solomon, MD, PhD**, Secretary of Health and Mental Hygiene.

Mr. Schmickel, who served as Connecticut's Deputy Commissioner of Health and headed the state's Office of Mental Retardation from 1959 to March 1971, assumed his office on June 1. In his new capacity, he will head the Directorate of Mental Retardation, which has been previously created by Dr. Solomon to combine activities in the field of mental retardation formerly operated by the Department of Health and Department of Mental Hygiene.

The cooperation of physicians is requested in the referral of patients with known or suspected **intestinal malabsorption**

for studies being conducted by the **National Institute of Arthritis and Metabolic Diseases' Digestive and Hereditary Diseases Branch** at the **Clinical Center, National Institutes of Health, Bethesda, Maryland**.

Needed for these studies are patients with such problems as local intestinal immune response in gluten-sensitive sprue and intestinal malabsorption associated with agammaglobulinemia and related disorders. The pathophysiology of Whipple's disease is under continuing study. Of particular interest for these and related investigations are patients with intestinal malabsorption of demonstrated or undiagnosed cause.

Upon completion of their studies, patients will be returned to the care of the referring physician, who will receive a summary of findings.

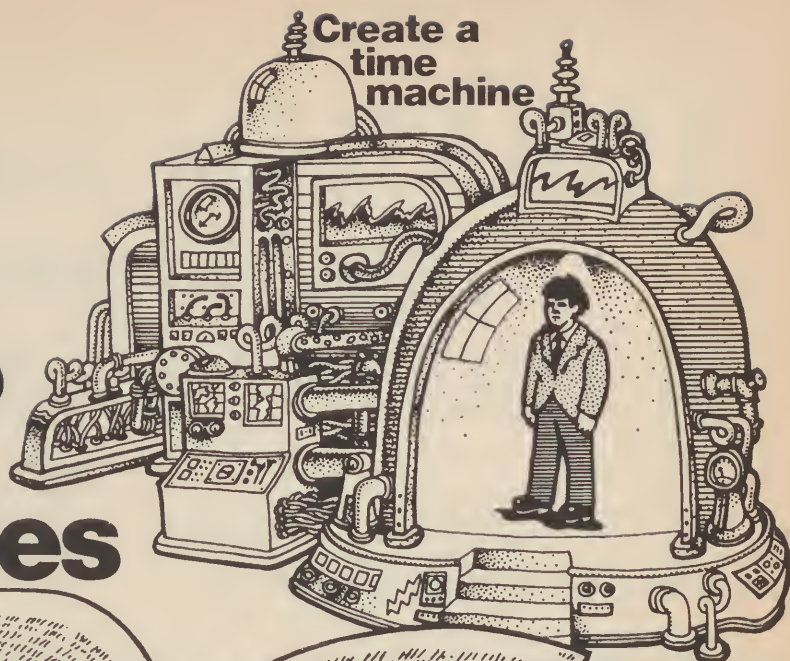
Physicians interested in having their patients considered for admission to these studies may write or telephone collect: **Saul G. Angus, MD**, or **Leonard Laster, MD**, Clinical Center, Rm. 9-D-15. National Institutes of Health, Bethesda, Maryland 20014, Tel. 301-496-4201.

The **American Board of Family Practice** announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two-day period on April 29-30, 1972. Information regarding this examination can be obtained by writing: **Nicholas J. Pisacano, MD**, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

**PLEASE NOTE: Deadline for receiving completed applications in the Board Office is FEBRUARY 1, 1972.**



# What to do until suppositories work:



Read  
"War and Peace"



Actually, on the average, evacuant suppositories take about an hour to work.<sup>1-3</sup> Sometimes two.<sup>4</sup> Sometimes more.<sup>3</sup> Also, suppositories can be ineffective in up to 38% of patients,<sup>5</sup> and not infrequently produce smarting, burning and tenesmus.<sup>6</sup>

Alternative to the long unpleasant wait: FLEET® ENEMA.

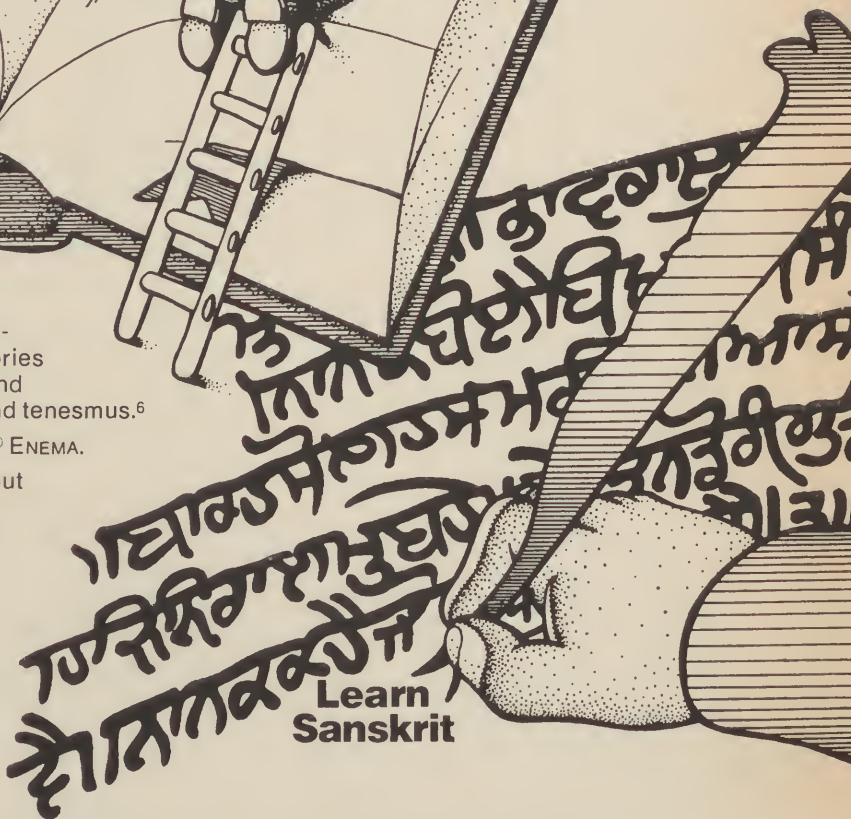
FLEET ENEMA works within 2 to 5 minutes without pain or spasm. FLEET ENEMA induces a physiological pattern of evacuation, unlike purgatives and laxatives that may liquefy the stool.

FLEET ENEMA avoids the irritation common with soapsuds enema. And FLEET ENEMA is leakproof: a rubber diaphragm at the base of the prelubricated tube prevents seepage and controls the rate of flow, assuring comfortable administration.

FLEET ENEMA. Regular and pediatric. Both completely disposable—like suppositories, only better. Much better.



C. B. FLEET CO., INC.  
Lynchburg, Va. 24505



Learn  
Sanskrit

**Warning:** Frequent or prolonged use of enemas may result in dependence. Take only when needed or when prescribed by a physician. Do not use when nausea, vomiting or abdominal pain is present. **Caution:** Do not administer to children under two years of age unless directed by a physician.

**References:** 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriatr Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.



# Call it what you will, it may be premalignant.

## Before

3/29/67 Before therapy with 5%-FU cream. Patient P.T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

## After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.







Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# and Efudex® (fluorouracil) 5% cream can resolve it.

Call it actinic, solar or senile keratoses,  
many regard it as "precancerous."<sup>1,2</sup>

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,<sup>3,4</sup> offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these multiple lesions.

## Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.<sup>5</sup> Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.<sup>6</sup>

## Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.<sup>5</sup> The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.<sup>6</sup>

## How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

## Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

**References:** 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T., and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis*, 6:293, 1970. 4. Sams, W. M.: *Arch. Derm.*, 97:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer*, 25:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

**Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).**



now

**Efudex®**  
(fluorouracil)  
cream/solution



# **1971 SEMIANNUAL MEETING PROGRAM**

## **MEDICAL AND CHIRURGICAL**

## **FACULTY OF MARYLAND**

### **BUSINESS SESSIONS — HOUSE OF DELEGATES MEETING**

**Saturday, September 11 at 2 PM**  
**Faculty Building, Baltimore**

#### **MEDICAL AND CHIRURGICAL FACULTY OFFICERS**

John F. Schaefer, MD, President  
William A. Pillsbury, MD, Secretary  
Karl F. Mech, MD, Treasurer  
John Sargeant, Executive Director

#### **COMMITTEE ON PROGRAM AND ARRANGEMENTS**

John B. De Hoff, MD, Chairman  
Albert M. Antlitz, MD  
James D. Drinkard, MD  
Edwin H. Stewart, MD  
Mrs. Robert A. Reiter, President, Woman's Auxiliary  
Genevieve Ritchie, Executive Assistant

## **SCIENTIFIC SESSIONS AND WOMAN'S AUXILIARY MEETING**

**September 15-19**  
**El Conquistador, Puerto Rico**

**Ten elective credits will be given by Academy of General Practice for attendance at scientific sessions.**



# SCIENTIFIC SESSIONS

## *The Child from One to Twenty-One*

THURSDAY, SEPTEMBER 16

John B. De Hoff, MD, Presiding

**10:00 AM EMOTIONAL DEPRESSION IN PUERTO RICAN YOUTH**

Standish McCleary Fund Lecture

**Enrique Rivera-Romero, MD**, Hato Rey, Puerto Rico

Child Psychiatrist, Director of Puerto Rico Psychiatric Institute

**11:00 AM OBLIGATIONS OF PHYSICIANS IN PUBLIC AFFAIRS**

Sponsored by MMPAC (Maryland Medical Political Action Committee)

**The Honorable Melvin H. Evans, MD**, Governor of the Virgin Islands

Albert M. Antlitz, MD, Presiding

**2:00 PM ENDEMIC PROBLEMS OF PUERTO RICAN CHILDREN**

Harvey Grant Beck Memorial Lecture

**Juan F. Jimenez, MD**, Santurce, Puerto Rico

Chief of Pediatrics, San Juan City Hospital

**3:00 PM NEWBORN CARE IN COMMUNITY HOSPITALS**

Harvey Grant Beck Memorial Lecture

(Cosponsored by Maryland Chapter, American Academy of Pediatrics)

**Iradj Mahdavi, MD**, Cheverly, Maryland

Clinical Assistant Professor of Pediatrics, Georgetown University School of Medicine, Washington, D.C.

THURSDAY, SEPTEMBER 16

WOMAN'S AUXILIARY MEETING

**Mrs. Robert A. Reiter**, President

**9:30 AM** Business meeting following which ALL AUXILIARY members and GUESTS are cordially invited to join the physicians for the 11 AM program presented by Governor Evans.

FRIDAY, SEPTEMBER 17

Albert M. Antlitz, MD, Presiding

**10:00 AM DISEASES PECULIAR TO PUERTO RICAN YOUTH**

George M. Boyer, MD, Lecture

**Pedro M. Mayol, MD**, San Juan, Puerto Rico

Assistant Professor of Pediatrics, University of Puerto Rico School of Medicine

*(Continued on next page)*



**11:00 AM HEALTH SYSTEM AND DELIVERY OF HEALTH SERVICES TO CHILDREN IN PUERTO RICO**

Amos R. Koontz, MD, Memorial Lecture

**Jaime Rivera-Dueño, MD**, San Juan, Puerto Rico

Assistant Secretary of Health, Puerto Rico, and Instructor in Pediatrics, University of Puerto Rico School of Medicine

**Edwin H. Stewart, MD**, Presiding

**2:00 PM MOST CURRENT SURGICAL PROBLEMS IN PUERTO RICAN CHILDREN**

I. Ridgeway Trimble Fund Lecture

**Luis Soltero-Harrington, MD**, Hato Rey, Puerto Rico

Attending Surgeon, Chief of Thoracic and Cardiovascular Surgery, Hospital del Maestro

**Elliott Michelson, MD**, Baltimore, Maryland, Discussant

Assistant Professor of Surgery, The Johns Hopkins University School of Medicine, and member of the Trauma Committee, Maryland Chapter, American College of Surgeons

**3:00 PM THE NEWER TECHNIQUES IN INTENSIVE CARE MANAGEMENT OF INFANTS AND CHILDREN**

J. M. T. Finney Fund Lecture

(Cosponsored by Maryland Chapter of American College of Surgeons and Trauma Committee of the Maryland Chapter of American College of Surgeons)

**J. Alex Haller, Jr., MD**, Baltimore, Maryland

Robert Garrett Professor of Pediatric Surgery, The Johns Hopkins University School of Medicine

**SATURDAY, SEPTEMBER 18**

**Edwin H. Stewart, MD**, Presiding

**10:00 AM DRUG PROBLEMS IN PUERTO RICO**

William Royal Stokes Memorial Lecture

**Fernando J. Cabrera, MD**, Santurce, Puerto Rico

President Puerto Rico Medical Association

**Ramon Fernandez-Marina, MD**, Santurce, Puerto Rico

Psychiatrist and Psychoanalyst, Hato Rey Psychiatric Hospital

**11:00 AM VENEREAL DISEASES**

Albert E. Goldstein Memorial Lecture

**Armando Beauchamp-Silva, MD**, Santurce, Puerto Rico

Assistant Professor of Dermatology, University of Puerto Rico School of Medicine

**SOCIAL FUNCTIONS**

**WEDNESDAY, SEPTEMBER 15**

**4:30 PM** Welcome Rum Swizzle Party  
(Courtesy of the El Conquistador)



**THURSDAY, SEPTEMBER 16**

**12:30 PM** Governors' Luncheon  
(Sponsored by the Woman's Auxiliary)  
Presiding: **Mrs. Robert A. Reiter**, President  
**EVERYONE INVITED**

**FRIDAY, SEPTEMBER 17**

**12:00 Noon** University of Maryland School of Medicine Alumni Luncheon  
Contact: Col. Francis W. O'Brien, University of Maryland Medical Alumni Association,  
522 West Lombard Street, Baltimore, Maryland 21201 (301-955-7455)

**SATURDAY, SEPTEMBER 18**

**6:30 PM** Gala Farewell Cocktail Party  
(Courtesy of Travel Guide Agency)

**7:30 PM** Dinner Dance  
Presiding: **John F. Schaefer, MD**, President, Medical and Chirurgical Faculty

**SPECIAL ENTERTAINMENT**

Vocalist

Fire and Limbo Dance Team

\* \* \*

Tours of St. Thomas, Old and New San Juan, Golf Tournament, Tennis Tournament, Swimming, Dancing, Cocktail Lounges, Casino, Fishing, Sailing, Horseback Riding, Shopping, etc, available. Complimentary steam, sauna, and gym privileges. Complimentary green fees for golf.

\* \* \*

**THE EL CONQUISTADOR**

The place to be  
where there's so much  
to do and see

SEPTEMBER 15-19, 1971

**Via Eastern Airlines**  
**747 Jumbo Jet**

Depart from Friendship Airport  
morning of Wednesday,

SEPTEMBER 15

Return to Friendship Airport  
evening of Sunday,

SEPTEMBER 19

**SEE RESERVATION FORM ON PAGE 42**



The Congress has been asked by the Administration to authorize an additional expenditure of \$155 million for the control of drug addiction.

In his special message to the House and Senate, President Nixon said: "If we cannot destroy the drug menace in America, then it will surely destroy us."

The Administration's program would:

- Make Veteran's Administration facilities available to all former servicemen in need of drug rehabilitation, regardless of the nature of their discharge, and provide \$14 million for this program.

- Seek \$105 million from Congress to be used solely for treatment and rehabilitation of drug addicts.

- Request an additional \$10 million to improve education programs on dangerous drugs.

- Request special legislation permitting the government to use information obtained by foreign police and other technical measures to make it easier to prosecute drug pushers.

- Ask for an additional \$25.6 million for the Treasury Department to expand efforts against smugglers.

- Request \$2 million to expedite research and development of detection equipment and techniques.

- Request \$2 million for the Agriculture Department to develop herbicides that would destroy narcotics-producing plants.

- Request \$1 million for assistance to other nations in training law enforcement officers.

Implicit in the Presidential drug control proposal is the endorsement of the use of methadone in the treatment of Vietnam veterans addicted to heroin. This high-level sanction of the heretofore somewhat controversial and experimental use of methadone marks a turning point in the nation's attempt to



rehabilitate addicts. Observers believe the decision to make wide-scale use of methadone was influenced by official recognition of the discouraging low "cure" rate from other approaches to the problem.

Named by the President to head the new drug control program was Jerome H. Jaffe, MD, a Chicago psychopharmacologist and director of the Illinois State Drug Abuse Program. Dr. Jaffe, an advocate of the methadone treatment method, will serve as a White House consultant until the new agency is organized.

Shortly after the announcement of the new drug control program, President Nixon asked the American Medical Association's House of Delegates meeting in Atlantic City to join in the nationwide war on drug abuse.

After detailing at some length the growing social dangers of drug abuse, the President said that there was a link between the inappropriate use of drugs within the medical context and the abuse of drugs outside that context.

"Consider these facts for a moment: In the last four years alone, the production and distribution of tranquilizers in our country has doubled. During 1970, 5 billion doses of tran-

## THE MONTH IN WASHINGTON

quilizers, 3 billion doses of amphetamines, and 5 billion doses of barbiturates were produced in this country. Listen to this: The estimate is that 50% of the amphetamines and barbiturates were diverted into illegal sales. So there is a problem in the terms of education as well as enforcement."

"Tranquilizers, amphetamines, and barbiturates, as you know, are known as psychotropic or mind-altering drugs. It is estimated that one third of all Americans between the ages of 18 and 74 used a psychotropic drug of some type last year. And little wonder—for there were enough drugs of this type available last year to medicate every adult in the United States at very high dosage rates for more than 11 days.

"We have produced an environment in which people naturally come to expect that they can take a pill for every problem—that they can find satisfaction and health and happiness in a handful of tablets or a few grains of powder."

\* \* \*

In addition to his call to physicians to assist in the drug control program, the President, in his Atlantic City address, also challenged organized medicine to provide the leadership "this



**country craves for" in all areas of health care.**

"The health of America is in your hands, and by its health I speak not just of its physical health (but) its mental health, its moral health, its character," the President said.

In immediate response to the President's challenge to American Medicine, the AMA's special communications program answered the Chief Executive's call for physician leadership in a full-page message that appeared in many of the nation's principal newspapers. The message, titled "We accept, Mr. President", responded point-by-point to Mr. Nixon's request for broad physician support in all aspects of the nation's health.

\* \* \*

**In a recent letter to the Bureau of Narcotics and Dangerous Drugs, the AMA stated that it will do everything possible to assist in implementing a proposed regulation that will curb the abuse of amphetamines and methamphetamines.**

"Physicians throughout the nation are concerned about the alarming dimensions of the drug abuse problem," wrote Richard S. Wilbur, MD, AMA's deputy executive vice-president. Pointing out that while the proposed regulation reclassifying amphetamines and methamphetamines as narcotics substances such as morphine, codeine, and opium would further inconvenience the practicing physician because of additional requirements concerning ordering, recordkeeping and prescribing", Dr. Wilbur assured the Bureau that most physicians were in accord with the proposed regulation.

The AMA letter followed quickly after the House of Delegates met in Atlantic City in late June and adopted the following resolution:

Resolved, That the American Medical Association urge all physicians to limit their use of

amphetamines and other stimulant drugs to specific, well-recognized medical indications, and be it further

Resolved, That the American Medical Association support the proposal of the Bureau of Narcotics and Dangerous Drugs to transfer Amphetamine and Methamphetamine and their Salts, Optical Isomers, and Salts of their Optical Isomers from Schedule III to Schedule II published in the May 26, 1971 *Federal Register*.

Congressman Paul G. Rogers (D.—Fla.), chairman of the House Commerce Subcommittee on Public Health and Environment, has lauded the AMA for being in the forefront in the support of the Health Manpower and Nurse Training legislation. In a letter addressed to the AMA Washington office, Congressman Rogers wrote:

"The date and expertise of the Association's witnesses were most helpful. The AMA's governing body wisely included medical manpower legislation as a part of the Association's legislative package. I feel this legislation is a keystone to any additional health programs that may be passed by the Congress."

\* \* \*

**Full funding of a number of new and continuing health programs has been urged by American Medical Association officials appearing before a House appropriations subcommittee.**

Maternal and child health care, communicable disease control and vaccination assistance, alcoholism prevention and treatment, and regional medical programs, as well as a number of newly proposed programs for the development of medical manpower, were endorsed with a request for full funding by Raymond T. Holden, MD, a practicing physician in Washington and a member of the AMA Board of Trustees.

Dr. Holden stressed "the

urgent need of increased financial support for the continuation of existing medical schools and for the continued development of new schools." He also asked for the subcommittee's full support for nursing education, and the development of allied health personnel to meet the manpower needs for the nation's health care delivery system.

Dr. Holden gave the AMA's support to the programs of prevention and control against venereal disease, rubella, measles, Rh disease, poliomyelitis, diphtheria tetanus, and whooping cough. He noted substantial progress in the past in reducing the incidence of diseases covered by the former Vaccination Assistance Act, but added: "we are greatly concerned with reports that indicate declining levels of immunization protection against measles, poliomyelitis and diphtheria in the United States."

The AMA spokesman also urged the subcommittee to appropriate the full \$100 million authorized by the Comprehensive Alcohol Abuse, Treatment and Rehabilitation Act.

In terms of economic loss, the unproductiveness of the alcoholic during his 30's, 40's, and 50's is augmented by the several billions of dollars industry loses annually through absenteeism and on-the-job accidents related to alcoholism and alcohol abuse.

Reminding the subcommittee that while the 1972 fiscal authorization for Regional Medical Programs (heart, cancer, stroke and kidney disease) is \$150 million, Dr. Holden said, "We do not believe the \$52 million currently requested for support is sufficient to adequately meet the needs for continuation and expansion of appropriate programs under this legislation, even though some \$34 million may remain available from previous appropriations."

\* \* \*



**MEDICAL AND CHIRURGICAL FACULTY  
SEMIANNUAL MEETING**

**RESERVATION FORM**

For

**EL CONQUISTADOR**

**VIA EASTERN AIRLINES 747 JUMBO JET**

Send to:

**COMMITTEE ON PROGRAM AND ARRANGEMENTS  
MEDICAL AND CHIRURGICAL FACULTY  
1211 CATHEDRAL STREET  
BALTIMORE, MARYLAND 21201**

I would like to make a reservation for the MED-CHI SEMIANNUAL MEETING at the El Conquistador Hotel, SEPTEMBER 15-19, 1971. Enclosed please find payment in full in the amount of \$ \_\_\_\_\_ (\$239 plus \$19.50 tax and service—total of \$258.50—a person) made payable to TRAVEL GUIDE AGENCY LTD., for # \_\_\_\_\_ reservations. Monies paid are refundable subject to resale of the reservation(s).

( ) First Class Supplement at \$25 a person

( ) Single room desired at supplemental rate of \$48

NAME			ADDRESS		
CITY	STATE	ZIP CODE	(home)	PHONE	(office)

Please list clearly the full names of all participants:

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## Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help—for these four very good reasons:

**Appeal** With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



**Nourishment** Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

**Convenience** Within 4 minutes a bowl of delicious soup is heated and ready to eat.

**Economy** Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*





**You can't  
treat one  
without  
the other.**



# A triumph over trichomoniasis

The male urogenital tract is by far the main source of reinfection in trichomonal vaginitis.

It follows that neglecting to treat infected male partners of women with trichomonal vaginitis invites therapeutic failure.

Just as Flagyl is the best agent available for eradicating trichomonal infection from extravaginal sites in women, it is the only agent capable of eradicating demonstrated trichomonal infection in men.

Because of published reports of consistently high cure rates—often up to 100 percent—and a relatively low incidence of side effects, Flagyl has become the agent of choice for trichomonal vaginitis.

**Indications:** For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

**Contraindications:** Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

**Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

**Precautions:** Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

**Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of

*Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

**Dosage and Administration:** *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

**Dosage Forms:** Oral tablets 250 mg.  
Vaginal inserts 500 mg.

References available on request.

# Flagyl®

metronidazole

care for the pair  
in trichomoniasis

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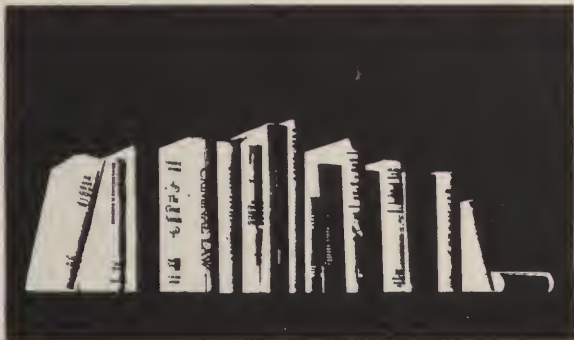
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PAUL F. GUERIN, MD, CHAIRMAN  
Library and History Committee  
ELIZABETH SANFORD  
Librarian

## library

# News of Personalities and Happenings at the National Meeting of the Medical Library Association

The Waldorf Astoria Hotel in New York city was the scene of the Medical Library Association's 70th Annual Meeting, May 30 through June 3, 1971. It was generally agreed that a holiday weekend is not the best time to arrive in New York if you like a choice of restaurants in or convenient to your hotel. But, nevertheless, everybody survived that inconvenience as well as that of continually having to search for meeting rooms scattered over a 2,000-room hotel.

At the first general meeting, an announcement was made that President Nixon had declared June 1, 1971 as Medical Library Association Day as a tribute to its devotion "to making the vast treasures of biomedical development accessible to science. The association has been responsible for advancing the practice of medical library science, improving the professional standards of medical libraries, and maintaining a liaison with other organizations dedicated to the improvement of health." Mr. Hubert Humphrey presented his S.J. Res. 103 proclaiming National Medical Library Day. He also mentioned that the Medical Library Assistance Act of 1965

has made funds amounting to \$40.8 million available to the medical community.

### MLA Honors and Awards

The two highest honors of the convention went to Dr. Estelle Brodman, Director, Washington University School of Medicine Library in St. Louis. Because of her reputation as historian, scholar, teacher, and editor, she was selected to deliver the Janet Doe Lecture on some aspect of the philosophy of librarianship.

In addition, she was presented the Marcia C. Noyes Award for her distinguished contributions to the profession. Dr. Brodman has authored *The Development of Medical Bibliography*, has served on the President's Commission on Libraries, and has been editor of the bulletin of the Medical Library Association, consultant for libraries in developing countries, and president of the Medical Library Association.

### MLA Scholarships

The \$1,500 MLA scholarship went to Margaret Lake Summers, AB, Texas Woman's University in



Denton, where she will work toward her MSLS.

The MLA/Jolowicz \$1,000 scholarship went to Lawrence B. Klein, a graduate of Roosevelt University, Chicago. He will attend Rosary College in River Forest, Illinois.

#### **MLA President, 1971-1972**

Mrs. Bernice M. Hetzner, Librarian and Professor of Library Science, University of Nebraska Medical Center, Omaha, is the new president of MLA, June 1971-June 1972, succeeding Donald Washburn, DDS.

The 1972 meeting will be in San Diego-Coronado, California at the Del Coronado Hotel, June 11-15, 1972.

#### **Baltimore Hospital Librarians' Association**

The new president for 1971-1972 is Miss Eleonore

Buehl, Librarian, Doctors' Library, City Hospitals in Baltimore.

At one of the last meetings this spring, the name of this organization was discussed, since librarians outside the metropolitan area do join and the present name does not indicate membership covering the state area. If you wish to express your feelings about this, contact Mrs. Elizabeth Sanford, Librarian, Medical and Chirurgical Faculty of Maryland, 1211 Cathedral St., Baltimore, Maryland 21201, or Mrs. Florence Brown, Librarian, State Department of Health, 13th Floor, 301 W. Preston St., Baltimore, Maryland 21201.

\* \* \*

Congratulations to Lyle Lodwick, formerly of Williams and Wilkins, now with Lyle Lodwick Publications, Inc.—a subsidiary of National Educational Consultants. They are located at 711 St. Paul Street in Baltimore.

### **NEW ACCESSIONS—BOOKS**

(Arranged by Subject)

#### **BIRTH CONTROL**

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

## **Baltimore City health department**

# **Child Lead Paint Poisoning**

There have been nine cases of lead paint poisoning reported to the Baltimore City Health Department so far this year, the same number of cases reported by July 31, 1970. As was the case last year, the poisonings showed a sharp increase in the month of May. This fact points up the experience of past years, that during months with higher temperatures more lead paint poisoning cases are reported.

So far in 1971, 82 cases of elevated blood lead in children have been discovered. This indicates that there are still places in the city where a child may ingest lead paint even though the amount ingested may not be sufficient to cause poisoning symptoms.

When a child has eaten a sufficient amount of lead paint, early signs of poisoning are pains in the abdomen, nausea and vomiting, irritability, lack of interest or persistent constipation. Later, if the child continues to eat paint, he develops frequent

headaches and finally, convulsions that can result in death.

It is dangerous, however, for parents to wait for symptoms to appear. Lead affects children differently and youngsters with high levels of lead in the blood may not show symptoms. Further, symptoms indicate the poison is already damaging the child's body and brain.

Parents should watch closely the activities of their preschool, teething age children particularly in the hot months ahead. If a child is seen eating paint or plaster from the walls, woodwork, or repainted household items such as cribs and chairs, he should be promptly taken to a physician or clinic. Early discovery can prevent the damage to the child's health that lead paint poisoning can bring.

Physicians are urged to be alert to child lead paint poisoning symptoms. Assistance in diagnosis may be obtained by calling 752-2000, extension 614.

## **New Clinic in South Baltimore**

A new clinic to provide broad adult and child services for citizens of the South Baltimore peninsula opened May 17 in the City Health Department's Southern Health District Building. The clinic is jointly sponsored by the City Health Department and Mercy Hospital in a continuing effort to make medical services less expensive and more easily available to people of the community served.

Although Mercy Hospital has provided a grant to start the new clinic, fees will be charged of some patients. These fees will be in line with fees of local physicians. It is expected that medicaid and patient

fees will make the clinic self-supporting after one year of operation without further grants from Mercy Hospital. Since the clinic does not have the same expensive facilities as the hospital, it is hoped that the cost will be less than treatment in a hospital-based clinic.

The new clinic in the Southern Health District building at 1211 Wall Street is open every day except Sunday from 9 AM to Noon. Patients are requested to make appointments by calling 727-3471, although patients who come to the clinic without an appointment will be served.



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C I B A

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**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide.

Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine:** Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

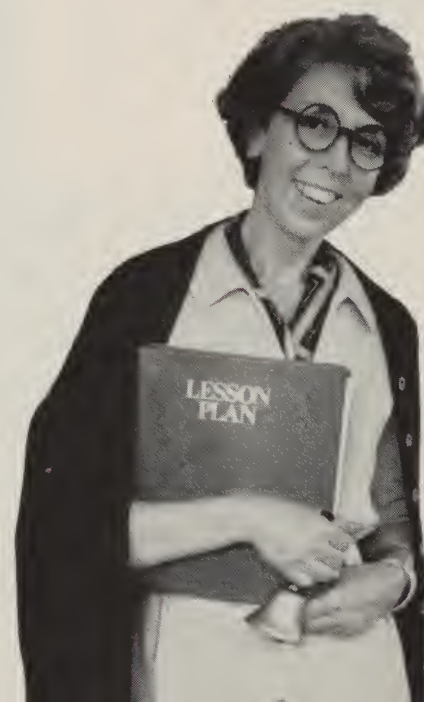
**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

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# C I B A





MRS. WALLACE H. SADOWSKY, EDITOR

woman's auxiliary

## Auxiliary Bids Bon Voyage to S.S. HOPE

The exciting news that Baltimore was to be the home port for the hospital ship *S. S. HOPE* prompted the Maryland auxiliary to sponsor a tour of the ship and a highly successful benefit "Bon Voyage" dinner in January.

Project HOPE had been a special interest of the auxiliary for a long time. In fact, several years ago the members had looked into the possibility of its coming to Baltimore for at least one of its home port dockings, but plans failed to materialize then. So the auxiliary was doubly delighted when the ship came to Baltimore this year for cleaning and refurbishing.

Their successful "International Evening" during the 1970 state convention (January, *MD'S WIFE*) had netted a \$1,072 profit, part of which was donated to Project HOPE for a badly needed croupette. The auxiliary's enthusiasm for the work the ship is doing, and their concern for the needs of the people the ship serves led them to still greater efforts. Appeals for specific articles were placed in their state auxiliary paper.

Now an additional project was planned, and this effort proved to be the high point of the auxiliary year. Because of the ship's scheduled departure for Jamaica, West Indies, on January 8, it was necessary for plans to be put into effect immediately. A tour of the ship was arranged for January 2, for auxiliary members, physicians, state and local leaders, and personnel ("Hopies") who have served on the ship in the past.

Following the tour, the group celebrated the ship's "home port" choice with a fund-raising dinner, program and raffle. Decorations for the gala event were appropriate: the blue and white of the Ship HOPE was complemented with red in a floral reproduction of the ship floating in an ocean near an island. This stunning centerpiece was made by Mrs. Leopoldo Gruss, state auxiliary international health chairman.

Red, blue, and white paper flowers decorating the tables and the wall panels of the room were made by Mrs. Gruss, Mrs. Rafael Perez Mera, and Mrs. David Morales. In addition, a three-foot white layer

cake decorated with a three-dimensional model of the ship was ordered and given to the HOPE personnel as a bon voyage gift.

A sumptuous buffet featuring roast beef, seafood, and Maryland fried chicken, along with all the trimmings, and an open bar was supplemented by music with "a West Indies feeling."

Following the dinner, the founder and director of the *S. S. HOPE*, Dr. William B. Walsh, Mrs. Walsh, and their son Tommy were introduced. A \$200 check for a croupette from money raised at the International Night was presented to Dr. Walsh, along with packages containing johnny coats and sheets and other supplies from the Baltimore county members. Later, an additional check for \$700, the proceeds of the tour dinner, was sent to him. Dr. Walsh spoke to the group on the realities of health care needs.

A former Navy serviceman told the group of his many years aboard the ship when it was the *U.S.S. Consolation* and showed pictures of the ship as it appeared 24 years ago.

An informal modeling of cruise fashions during the cocktail and dinner hour featured both professional models and physicians' wives.

Eastern Regional IHA Chairman Mrs. H. L. Warres of Baltimore and Maryland State Auxiliary President Mrs. Raymond Yow joins with Mrs. Gruss, who was born in Argentina, in her enthusiasm for Project HOPE. It is, she believes, "a true show of how the United States of America cares for the underdeveloped countries. With deep and sincere sense of humanity the *S.S. HOPE* carries a responsibility as ambassador of American medicine . . . a step to gain better health for the sick people of the world, and more smiles and more love from our neighbors."





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# The Conduct of an Operation

**ROBERT W. BUXTON, MD\***  
Professor and Chairman  
Department of Surgery  
University of Maryland School of Medicine  
Baltimore

*\* Dr. Buxton died on August 14, 1970.*

This article deals with the conduct of a surgical operation in which much thought is given to the prevention of sequelae to that operation, which sequelae may lead to a more prolonged acute morbidity, a further operation, or to death of the patient. Perhaps this is better said in a set of aphorisms attributed to my predecessor at the University of Maryland, Dr. Arthur Shipley, to wit, there are three obvious Rules for the Surgeon: 1) To have a live patient, 2) not to leave the patient with something worse than the disease he presently has, and 3) to produce no new disease.

The following discussion is motivated by a desire to fulfill these requirements by the proper conduct of an operation.

The preparation of a patient for a surgical opera-

tion, the conduct of that operation, the insistence of the patient upon relief or minimization of his immediate postoperative discomfort, the limitation of activity in the succeeding postoperative days, rep-



resent an astonishing combination of acts that prevent the individual patient from exchanging efficiently his respiratory gases with the air of his environment, and from propelling normal or desirable amounts of blood through the pulmonary vascular tree.

Hypoventilation results regularly with the use of the majority of the narcotics and barbiturates given preoperatively, from most of the agents used as general anesthetics and the drugs used postoperatively for the relief of pain. When to these are added parasympatholytic drugs, such as atropine and scopolamine, which make the bronchial and tracheal secretions viscid and tenacious, when we recognize that curarizing agents may produce bronchoconstriction, as may some anesthetic agents, and when the surgeon positions the patient on the operating table so that optimal exchange of gases and uniform blood flow disposition are compromised, severe ventilation-perfusion imbalances take place. Add to these the poorly standardized, sometimes carelessly applied manual compression of the anesthesia bag and there is still further impendence to the proper exchange of respiratory gases.

#### **The Time Factor**

There are other factors that may exert a detrimental influence on pulmonary function and deserve at least brief mention. One of these is steadily and regularly denied by most surgeons as a considerable factor in postoperative pulmonary complications. This factor is the duration of operation, or anesthesia time. It has long been a platitude passed on from older surgeon to younger surgeon that as long as the operation is done gently, precisely, and with minimal blood loss, speed is an unwarranted goal—that speed is of necessity associated with increased error and roughness. These observations have indeed the capacity to contribute to error and to a difficult postoperative course compounded by many complications.

In a study by Gold and Helrich from the Department of Anesthesiology at the University of Maryland, a further interpretation of the time factor in surgical operations was made. Their study dealt primarily with anesthesia and anesthetic agents in patients with bronchospastic disease (bronchial asthma). An attempt was made in this study to assess the role played by anesthesia and by surgery in the production of operative and postoperative complications. In this study, 220 anesthetics were administered to 196 asthmatic patients and their course compared to 100 randomly chosen nonasthmatic patients all subjected to a variety of surgical procedures and a wide variety of anesthetic agents.

In this study there was excellent correlation between the incidence of complications and the dura-

tion of anesthesia and operation, varying only in magnitude between asthmatic and nonasthmatic patients. It appears in this study that the increase in complications with time is a geometric rather than a linear function, the liability becoming much greater as time goes on.

#### **Site of Operation**

Many, many other factors can be incriminated in the study of intraoperative and postoperative complications: for example, surgery of the chest and abdomen account for four times as many complications as operations in other areas of the body; men asthmatics encountered significantly more complications than women. Nonetheless, the duration of operation contributed significantly and predictably to the number of intraoperative and postoperative complications, regardless of the anesthetic agent used or the anesthetic technique employed. Duration and site of operation are probably interdependent in the development and magnitude of these complications.

One is hard-pressed to find anything benevolent to say of the subsequent transfusion failures of physicians after Richard Lower conducted his first transfusion at Gresham College in Oxford in February 1665. One of those benevolent influences however was the continuing emphasis for improvements in technics for operative hemostasis. If surgeons were to take advantage 300 years later of the mastery of anesthesia and of operative sepsis, careful hemostasis was essential. Not until 1900 was blood-typing recognized as essential, and not until the 1930's was transfusion employed as a procedure other than that of last resort and in desperation. Today it is even difficult to recall the period when blood transfusion was given with caution or restraint.

#### **Complications in Transfusing Whole Blood**

One of the natural outgrowths of the discoveries which led to the transfusion of whole blood has been the recognition that shock was due, in the majority of instances, to a reduced circulation volume of blood and that in instances of this sort the most effective therapy was the transfusion of whole blood. With the development of blood banks and the increasing ease of blood procurement and storage, came the wider use of large volumes of blood replacement in extensive operative surgery in the fields of cancer, surgery of the opened heart, and trauma. Today, all surgeons use whole blood regularly and frequently and, as regularly, acknowledge that there may be several undesirable reactions to this practice of whole blood transfusion. Most of these may relate to pyrogenic and allergic responses, the reaction to aged blood stored for too long a period, to circulatory overload, citrate intoxication, bacterial contamination, and several other hazards all of which are increasingly less frequent.



One of the most disastrous and disturbing complications is that which occurs following the administration of mismatched blood. This rarely occurs today; in the period prior to World War II it was of great frequency because of our use of weak or poor typing sera. It should occur rarely today—it has been speculated that this should be less than 1 in 5000 to 10,000 transfusions if proper precautions are observed. When such an error does occur it is equally or more likely due to faulty blood issue or administration. In a large hospital facility the improper identification of the patient, the mixing of patient blood samples, and the unwitting administration of blood wrongly identified is easily possible and will contribute to an increasing frequency of transfusion mistakes.

The surgeon is aware of all such possibilities; too often he may not have defined the course he should follow when this event has occurred. To do so he must be aware of the lesion produced by the misadministration of whole blood.

The recognition of this catastrophe is important and readily apparent when recalled to mind. The onset in the awake and alert patient is usually a chill during the early administration of whole blood, and this is followed by pain in the lumbar region, flushing, cyanosis, substernal pain, headache, and rapid and shallow breathing. There is usually distention of the neck veins, sometimes nausea and vomiting, anxiety, and fever. When one examines the patient, there is commonly hypotension, tachycardia, prostration, and collapse. Hemoglobinemia will be found within one to two hours and jaundice becomes apparent within the first 24 hours. Hemoglobinuria, present early, may disappear within 24 hours as oliguria appears.

The symptoms and many of the signs may not occur when the patient is under anesthesia and for this reason the surgeon must be aware constantly that this is so; under these circumstances unusual bleeding from cut surfaces may be very prominent and possibly the only overt early sign that improper blood has been or is being given. This may be associated with thrombocytopenia, hypofibrinemia, and hypofibrinogenemia, and hypotension may occur.

Death may supervene rapidly, it may occur within ten days or the patient may slowly improve when a copious diuresis occurs.

The prompt hemolysis which occurs intravascularly following the administration of mismatched blood is alarming and results in hemoglobinemia, hemoglobinuria and jaundice. This sequence of events has occasioned the real concern that hemoglobin, or acid hematin were the sole responsible agents in the production of renal shut-down and tubular necrosis. Maluf however has shown that normally hydrated dogs may withstand intravenous injection of lysed canine red cells in a volume equivalent

to the infusion of more than a liter of incompatible blood into a 70 kg man. In dogs this tolerance was true in spite of aciduria. Flink noted that when the initial concentration of hemoglobin in the plasma exceeded 3.7 gm/100 cc renal insufficiency developed; Bing noted 0.5 to 1.0 gm of Hgb/kg was innocuous. O'Shaughnessy and others injected intravenously into a human patient 50 gm of human hemoglobin (equivalent to 300 cc of incompatible blood) within 30 minutes. No obvious renal damage occurred. Gilligan noted chills, fever and abdominal pains in a patient receiving 16.4 gm, ie, 0.25 gm/kg. Thus, acute renal failure was produced in neither animals or man by the quantities of blood or hemoglobin injected. Free hemoglobin does not of itself produce renal vasoconstriction. However, when shock plus hemoglobinemia are produced coincidentally renal shut-down occurs.

#### Studies With Animals

In animals this combination of pigment plus hypotension results in a decrease in effective renal blood flow and an immense fall in glomerular filtration. The resultant oliguria may or may not be productive of a concentrated, but of a dilute urine and thus a nearly normal urine volume may mask a severe renal shut-down. The mechanism of renal failure in animals, and presumably in man, then seems due primarily to tubular obstruction from casts of hemochromogen combined with a low rate of glomerular filtration from shock (in severe dehydration). The sequence of events, as studied in animals and the lesion which seems comparable to that seen in man includes: The deposition of protein pigment in the distal or collecting tubules, dilation proximal to this pigment cast, flattening and destruction of the tubular epithelium, restoration of the tubule, and ultimate discharge of the cast. The recognition of this lesion and the observation that a similar histologic lesion occurred in man led to the further observation that by variation of the amount of pigment the degree of damage to tubular epithelium could be varied and, in the experimental model, the mortality rate adjusted to any desired level.

These observations led, then, to a consideration of tubular urine flow. Within a short period it was recognized that the administration of a solute diuretic, at the time of pigment injection, served to protect animals from death. Urea, sucrose, glucose, sodium chloride, sodium sulfate, THAM, and mannitol, were all effective. The most dramatic effect is with mannitol. In a further study by Myers it was found that adequate hydration using either oral water or IV mannitol was protective and that water loading before pigment administration was also protective. Thus, all of these studies have concluded that the presence of reduced tubular urine flow, with its attendant urinary acidification and concentration, the presence of a difficultly soluble protein will ini-



tiate cast formation, tubular obstruction, swelling of the kidney with oliguria, azotemia, uremia, and death. And, reduced tubular urine flow can occur either with volume defects, vasoconstriction or antidiuretic hormone administration.

These experimental observations lead to the clinical conclusion that adequate preoperative hydration and adequate urine flow are prerequisites to safe major surgery and blood transfusions. The institution of adequate tubular flow as soon as possible following the administration of mismatched blood with the manufacture of dilute urine in large volume is the best protection against renal disease from this etiology.

In all experimental studies the time of administration of the diuretic agent appears critical. In the studies of Parry and Schaefer a delay of 30 minutes changed the mortality rate from 1.1% to 73%. After one hour, the mortality rate was 100% and the more closely the appearance of the kidney was to the untreated pigment kidney. Thus, the time factor seems of exceptional importance and can be explained in part, at least, by the observation of Powers on the shock kidney wherein he observed a progressive reduction in enzymes in the loop of Henle, following trauma, which was progressive.

In addition, there were marked alterations in the mitochondria seen most prominently in cells of the ascending loop. These changes were prevented, and even reversed by the administration of mannitol to Power's animals. Peters has suggested that the mechanism of these changes was vasodilation of the afferent arteriole. Herms has demonstrated that mannitol markedly limited the concentrating ability of kidney cells and suggested that this would produce a large flow of dilute urine and would tend to prevent the accumulation of pigment within tubular limina.

The studies of Flotte from this department have tended to confirm these observations. He and others now feel that the prophylactic administration of mannitol is equally effective and likely more desirable.

In situations of great urgency, when the awareness of the administration of mismatched blood becomes suddenly apparent, 12.5 or 25 gm of mannitol should immediately be administered by syringe, followed by infusion of 50 gm of mannitol in saline or Ringers solution or lactated Ringers solution at a slower rate. The urine flow should be kept at 1 cc/min and a dose of 50 to 75 gm of mannitol should be considered maximal.

Intestinal obstruction occurring after abdominal operations is always a threat to successful convalescence. In the early postoperative period, it has been estimated that 90% of small bowel obstructions are due to intestinal adhesions.

#### **Preventing Adhesions**

A discussion of the mechanisms involved in the production of peritoneal adhesions seems to revert

always to a generally accepted thesis that various traumata are responsible. However, the exact manner in which physical injury, chemical injury and the presence of foreign materials stimulate the formation of fibrous tissue in the peritoneal cavity is speculative. From these speculations has evolved a series of measures of prevention of these adhesive bands. The fact that the bowel often can undergo extensive trauma without the subsequent formation of adhesion suggests that some local preventive mechanism is normally active. Hartwell has suggested that serosal cells "prevent adhesions by combining their fibrinolytic power with their epithelial-like function of extending themselves as a solid sheet of cells to cover smoothly any raw surface. This gives them the ability to come between any two opposed musculofibrous surfaces which are stuck together only by fibrin which has not yet been organized by growth of granulation tissue or laying down of collagen. . . . If fibroplasia appears between two surfaces before motion or before serosal cells grow in to separate them, a permanent adhesion will be formed."

A successful approach to the prevention of adhesions is built on the following information: Lymphocytes, plasmacytes and mast cells synthesize and release several substances that are important in the metabolism of connective tissue. Fluctuations in the rate of formation, infiltration and lysis of these cells provide cellular mechanisms for serosal systems of balances and counter balances that control activities of interstitial fluids and metabolism of connective tissues.

Lymphocytic infiltration and plasmacytogenesis, such as occur in inflammations, concentrate neucleoproteins in an area of connective tissue. By dialytic exchange, cytoplasmic budding and lysis, lymphocytes release trephones into interstitial fluids. Plasmacytogenesis in connective tissue is a process of synthesizing antibodies, RNA and other proteins, and a means by which these proteins are stored intracellularly between the period of increased capillary permeability and proliferation of cells in localized areas of connective tissue.

Mast cells synthesize, store and release histamine, which incites hyperemia and induces capillary leakage of proteins and reduces the viscosity of hyaluronic acid in interstitial fluid. Usually these changes result in increased passage of plasma proteins, including the largest molecules, from terminal vascular structure into tissue interstices. Increased interstitial proteins stimulate the formation of stem cells of mast cells.

It is conceded that regeneration and repair of connective tissue is initiated by tissue edema, which brings about a release of water-binding mucopolysaccharide from mast cells and thereby mucinous organization of the water. The presence of muco-



polysaccharide stimulates deposition of collagen fibrils and fibrous organizations. Once deposited collagen is a practically inert substance with a very slow turnover.

The prevention of adhesion formation must control the following factors:

- 1) Minimization of the initial trauma and inflammatory response to trauma.
- 2) Prevention of "sticking" of serosal surfaces.
- 3) Delay of collagen formation and fibroblast organization where "sticking" has occurred, thus allowing the growth of serosal cells over this injured surface.

It is suggested that the early exudative phase in traumatized tissues is due to the increased production of histamine.

The bulk of evidence indicates that there exists an electrical potential across cell membranes, that a lower potential exists in the interior of cells than on their surface, that these potentials are normally maintained and modified by relative concentrations of ions within and without the cells and by metabolic actions of the cell. With any form of injury to cells a more direct connection is made with the inner portion of the cell and the cell membrane is said to take on a more negative charge. Much of the adherence of tissues following injury may be related to the adherence of positively charged (uninjured) cells to damaged negative surfaces. The adherence of such cell surfaces could be ameliorated by coating them with a solution carrying a uniform charge.

Collagen formation and fibroblast organization are inhibited by cortisone which causes a) lymphocytolysis and inhibits formation of lymphocytes, plasma-cytes and mast cells; b) tones histamine dilated arterioles and decreases capillary permeability (probably by inhibiting the action of hyaluronidase, histidine decarboxylase, and histaminase); c) inhibits vasculonization; and d) inhibits edematous swelling and degeneration of collagen fibers.

#### Attempts to Delay Adhesion Formation

An intraoperative measure must then be devised which minimizes the initial inflammatory reaction following trauma, helps in dissolution of fibrin, and delays fibroblastic proliferation, migration and organization.

Several years ago (1966) Replogle, Johnson, and Gross made one of the early, logical attempts to delay adhesions in infants undergoing laparotomy for meconium ileus, atresias and stenosis. There was a 25% incidence of adhesive obstruction in these infants postoperatively, resulting in 33% of the fatalities. A study begun on experimental animals and carried eventually to their patients suggested that the use of an antihistaminic promethazine (*Phenergan*) and a steroidal hormone dexamethasone

(*Decadron*) for 36 hours, only after operation served to reduce remarkably the occurrence of adhesions in animals and the incidence of adhesions in patients as evidenced by the lack of further intestinal obstruction.

(Dosage Schedule: 1 mg/kg (of each drug) six hours preop., three hours preop., intraperitoneally at laparotomy and I.M. q four hours postop. for 24 to 36 hours.)

Since adhesion formation begins immediately after peritoneal injury it seemed to us that prevention of the adherence of raw or wounded surfaces required a high level of drug concentration and distribution. Since it is known that low and medium molecular weight dextrans tend to reduce the aggregation of cells probably by changing surface electrical potential, and in the instance of intestinal serosa, by interfering with the appearance of fibrin on the serosal surface—a "siliconizing" effect—this measure was used in the laboratory to reduce adhesion formation on animals. Later the technique was used on patients.

In the laboratory at the University of Maryland, Flotte found that a stripping of the serosa from the terminal ileum in rabbits for an area 10 x 1 cm resulted in a uniform production of adhesions in this region. Flooding the peritoneum with saline failed to change this sequence while a similar flooding with commercial dextran resulted in 0-1+ adhesions. Crushing of the bowel with a hemastatic clamp showed a similar frequency.

Following this study, more than 250 patients at the University of Maryland Hospital and the Maryland General Hospital have had 250 cc of commercial dextran instilled into the peritoneum following laparotomy. It was soon found that after a thorough lavage of all bowel surfaces the dextran should be partially aspirated and discarded; a large amount left within the cavity tends to increase postoperative ileus and may contribute to the "sticking" of bowel surfaces in this late period. Of interest have been the 11 patients who came to subsequent operation (two with abdominal aneurysms, nine for other lesions) where a careful observation of the cavity revealed either no adhesions or an occasional band only.

Today it is suggested that the preoperative routine of promethazine and dexamethasone at six and three hours preoperatively and q four hours postoperatively for 36 hours and the instillation of 250 cc of dextran into the peritoneal cavity at the termination of laparotomy is a logical and perhaps ideal solution for the prevention of intestinal adhesions in the high-risk patient.

It would appear then that denuded surfaces in the peritoneal cavity readily heal by proliferation of peritoneum at the margins and by condensation of connective tissue in a denuded area unless infection or some other factor supervenes which re-



sults in long adherence of these denuded surfaces with the ingrowth, or in some individuals overproductions, of fibrous tissue to form adhesions. This observation is not a particularly new one since for many years surgeons attempted to initiate early, and to enhance peristalsis by the administration of "prostigmin" on a four-hourly basis immediately after operation. How soon peristalsis can be effectively initiated after operation is unknown.

Nonetheless, in the experimental animal both early feeding and prostigmin does exert a moderate, but definite preventive effect on adhesion formation. This administration of drug is not a popular method today. Perhaps this is so because Trompke and Seigner showed in 1956 that mechanical force could separate adherent peritoneal surfaces for only about the first three hours. Thus, the present efforts at prevention of this adherence gains some reason. Nonetheless, the surface acting agents (dextran) and the antihistamine agents given over a short interval are largely dissipated by 36 to 48 hours. Return of normal bowel motion and activity at this time becomes a most desirable goal.

#### Administering Fluids

The majority of patients coming to operations receive for a varying number of reasons quantities of electrolytic and crystalloid solutions in the replacement of intra- and postoperative volume needs regardless of the nature of the loss. Preoperative administration of fluid may be undertaken for repair of several losses due to the patients presenting disease process. Most patients, however, will begin their operation in a relatively normal state of hydration and the intraoperative and postoperative administration of fluids is undertaken to replace or supply calculated insensible and sensible losses. The basis for such calculations are often empiric and speculative. On the one hand Shires' work on experimental subjects showed that in shocked animals the extracellular fluid (ECF) space diminished by as much as 43%. Studies done on man also showed a marked loss of ECF. The disappearance of fluid from the ECF space was then reported to occur not only in shock, but also in patients undergoing major operative procedures. Deficits in ECF of up to 28% occurring with conventional fluid therapy during operation could be corrected by the administration of Sodium Lactate Solution. These chemical and experimental studies suggested that patients receive during an operation from 500 to 1000 ml/hour of Isotonic Ringers Solution.

More recently Roth, Lax, and Maloney have sharply questioned the rational of the administration of such volumes of fluid. Their carefully controlled studies on both animals and man have shown little or no change in the measureable volume of fluid in the extracellular or interstitial fluid spaces

after 1.5 hours of profound shock (5.7% mean decrease) in dogs, and a change of  $-0.6\%$  in patients undergoing cardiac surgery and of  $+0.2\%$  in patients undergoing major abdominal operations.

These authors cast much doubt upon the validity of the current methods of determination of patient fluid needs in terms of volume, sodium requirement, and the use of lactate solution. Moreover, they cite many instances of postoperative pulmonary edema as a sequel to the current fluid and electrolyte loading enthusiasts.

It is suggested that the not uncommonly seen prolonged postoperative ileus in patients after laparotomy may have the same etiology, but in a form less extravagant and less catastrophic than that seen as acute pulmonary edema. The following two case reports are examples of such entities.

#### Case Reports

I A. G. W. (37-10-52)

A. W., a 67-year-old woman, was admitted on September 22, 1968 at 10 PM complaining of abdominal pain, nausea, and vomiting for three days. On the evening of September 19, 1968, she had three dark, liquid "explosive" bowel movements and simultaneous lower abdominal colicky pain. The pain gradually increased and was followed by progressive distention, nausea, and vomiting. For six months preceding admission, constipation required laxatives for colonic evacuation. She denied weight loss, hematemesis, or melena.

She was well developed and well nourished, in moderate distress from abdominal pain, and there was clinical evidence of moderate dehydration. Blood pressure was 140/80 mm Hg, the pulse rate 110, respirations 20 per minute and rectal temperature 101 F. The abdomen was distended and tender with generalized rebound tenderness and moderate muscular rigidity. Maximum tenderness was present in the right lower quadrant.

On pelvic and rectal examination there was maximum tenderness in the cul de sac and on the right side of the pelvis.

Admission laboratory values were:  $\text{CO}_2$  25mEq/l,  $\text{Na}^+$  4.0 mEq/l, BUN 34 mg/100 ml and blood sugar 154 mg/100 ml. Routine urinalysis was negative except for a trace of albumin. Urine specific gravity was 1.032. (The bladder contained 15 ml urine.) Hemoglobin was 10.0 gm/100 cc and hematocrit 35%. White blood cell count was 11,700/cu mm with 85% polymorphonuclear leukocyte. The serum osmolality was 309 mOsm/kg and serum water was 94.3 gm/100 ml.

Over the next 14 hours, the patient received 4,200 ml 5% Dextrose in Ringer's lactate and 500 ml plasma. During the operation and in the immediate postoperative period through 7 AM on September 24, 1968, the patient received an additional



3,000 cc of D<sub>5</sub> in Ringer's lactate and 750 ml plasma.

Through September 26, 1968, intravenous therapy consisted of electrolyte and crystalloid solutions mainly in the form of D<sub>5</sub> in Ringer's lactate with adequate amounts of KCl added. During this period, she was somnolent and would fall asleep while being examined. The abdomen remained distended and there were no bowel sounds. Urinary output, which had been adequate, decreased to 410 cc on September 27. Laboratory values on September 27 were: Na 139 mEq/l, Cl 94 mEq/l, K 4 mEq/l, BUN 11 mg/100 ml. Serum water concentration was 95 gm/100 ml and serum osmolality 282 mOsm/kg. Over the next 48 hours the patient was given approximately 120 gm protein in the form of whole blood (1,000 ml) plus 50 gm serum albumin. She responded with urinary output of 1,400 ml on September 27 and 28, 1968. Bowel sounds returned and oral feedings were begun. On September 29, serum water concentration was 93.5 gm water/100 ml of serum and the osmolality 280 mOsm/kg. Further convalescence was uncomplicated.

#### Comment

The initial elevated osmolality in this patient reinforced the clinical diagnosis of moderate dehydration. Since serum water concentration (gm/100 ml) is a relative value, the admission level of 94.3 gm water/100 ml of serum in the face of moderate dehydration should have suggested advanced protein depletion. In spite of this, large quantities of Ringer's lactate and inadequate amounts of plasma to compensate for third space loss of albumin into the peritoneal cavity were administered. This resulted in restoration of iso-osmolality but further dilution of intravascular protein. Symptoms not only were similar to those of water intoxication (in spite of a normal osmolality) but also responded to restoration of water homeostasis following infusion of large amounts of colloid.

II M. J. (18-65-27)

M. J. was a 60-year-old woman admitted for sigmoid polypectomy. X-ray studies indicated diverticulosis of the ascending colon.

At operation, a right colectomy and removal of sigmoid lipoma were done. No parenteral fluids were given postoperatively; bowel sounds were active on the first postoperative day. Oral fluids were started on the second postoperative day and the patient discharged on the fifth postoperative day.

#### Shock

Surgeons are generally very aware of the state or condition of shock, of its varied etiologies and are particularly versed in its successful treatment. Today we know a great deal of the physiologic and patho-

logic changes accompanying shock, we are accustomed to the quantitative changes which occur in surgical and traumatic shock and are prepared to treat these, and I believe we are fairly clear about the changes which result in irreversible shock.

Some of the sequelae of shock which occur to the successfully resuscitated patient are often less appreciated—and as a result patients may be lost in the post-resuscitation period, particularly from overwhelming infection.

There are many documented instances of the increased incidence of infections following the necessary surgical treatment of patients with severe hypovolemia and hypovolemic shock. Paine in his report on 684 patients with bleeding peptic ulcers treated by resection noted major postoperative complications in one third; one half the complications were some type of infection involving either the abdominal incision or the peritoneal cavity. One fourth of the deaths in these patients were due to infections.

Redfern, Close and Ellison in discussing intra-abdominal abscesses noted 53% of their patients, with postoperative abscess, had an episode of shock or significant hypotension prior to, during or immediately following operation. Shock was due usually to hypovolemia from blood loss.

We have been particularly interested in this aspect of post trauma-post shock sequel. One particularly pertinent study done in our laboratory by Ollodart and Mansberger seemed particularly significant. This was a study of the effects of hypovolemia and shock on bacterial defense mechanisms in terms of the specific parameter related to bacterial phagocytosis. Phagocytosis by either moving or fixed phagocytes involves initial "coating" of bacteriopsinization,—approximation of phagocyte to bacteria—contact time,—engulfment and intraphagocytic bacteria killing.

#### The Role of Opsonins

Serum or plasma opsonins, two of which are complement and bactericidal antibody, prepare the bacterium for ingestion and are necessary for efficient phagocytosis; a part of this preparation is beginning injury of the bacterium by enzymes which are probably esterases. Once opsonized the bacterium can be brought into proximity of phagocytic cells and much of this depends upon blood flow to organs with large networks of reticuloendothelium (RE). When the opsonized bacterium is finally brought to the phagocyte the integrity or "metabolic health" of the phagocyte must be such that it is able to perform this function of engulfment. If the cell is anoxic or acidotic as a result of poor perfusion there may be a further delay in this cells' engulfing and destroying the bacterium.

The correction of the deficits is important and must be done with forethought. Banked whole blood is lacking in labile opsonins such as complement and



may contain free hemoglobin which will inhibit in varying degree the functions of the RES. Thus, in addition to the restoration of adequate blood flow to perfuse such essential organs as the liver, it is important that the blood supplied be fresh, with a full quota of plasma opsonins. To this time it has not been feasible to isolate, purify and store these factors separately for later use.

The studies done by Ollodart and Mansberger on animals and on 11 humans in severe hypovolemic shock, seen in the University's Shock-Trauma Unit have demonstrated this reduction in phagocytic index and reduced levels of complement in the bloods of both patients and animals. Shocked animals studied for clearance of aggregated albumin by the RES showed an impeded clearance after a 15% estimated blood volume hemorrhage. Bacterial clearance was similarly impaired.

Thus, the effect of hypovolemic shock in bacterial phagocytosis is the sum of a series of impairments each of which offer opportunity for correction by appropriate therapeutic measures. These must be initiated at the beginning of a hypotensive episode, if possible, and supplemented in the postoperative period by the usual measures in wound care and the use of appropriate antibacterial agents.

## Summary

The conduct of a surgical operation includes the recollection of all those factors which may in one way or another reduce the postoperative morbidity and the likelihood of a future uncomplicated by undesirable sequelae attributable to the initial operative performance.

Some of these sequelae may be prevented by:

1. A short operating time;
2. The early recognition of incorrectly identified blood for transfusion and the prompt administration of an osmotic diuretic;
3. A concentrated and logical attempt to minimize or prevent the occurrence of intestinal adhesions, particularly in the high risk patient;
4. Care in the administration of fluids at operation and particularly in the immediate postoperative period. Some thought should be given to the administration of no fluids whatsoever;
5. The use of fresh whole blood and antibiotics prophylactically on patients who have suffered a prolonged episode of severe hypotension or shock.

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# Task Performance and Task Delegation in General Practice

## Implications for Training of Physician's Assistants

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In recent years, there has been an increasing number of reports on the need for and use of trained physician's assistants and it has been estimated that their use increases physician productivity some 30% to 50%.<sup>1-3</sup> Several institutions are now training assistants who would be capable of performing a variety of tasks and procedures as well as assuming clinical responsibilities.<sup>4</sup>

We have been considering the development of a training program for physician's assistants who would be working with Maryland general practitioners. Since the training program should be relevant to the current activities of the physician's office practice and to those tasks he would delegate to the trained assistant, it was felt advisable first to gather information from Maryland practitioners, with this assessment focusing on answers to the following questions:

1. How much time is spent daily by Maryland general practitioners in the performance of certain technical procedures and treatment activities?
2. To what extent are these practitioners delegating responsibility to other office personnel for technical procedures and other tasks?
3. To what extent is there interest among practitioners in hiring a physician's assistant and what duties and responsibilities would be assigned to him?

This paper reports the results of studies designed to answer these questions.



Information was collected from two related studies: (1) a physicians' office survey where medical students made direct observation of physicians' time spent in certain procedures and tasks; and (2) a questionnaire completed by general practitioners in Maryland.

**Time Study of Physicians' Office Practice:** This study was conducted in the summer of 1969 with the data collected by five medical students who were summer fellows in the Division of Family Medicine of the University of Maryland School of Medicine. The procedures and activities included in the study were identified and placed in eight categories (Table 1). Forms were then prepared to record the time actually spent by physicians in the performance of these tasks.

After being instructed on the use of the prepared forms, the students pretested them in the office practice of five physicians who did not participate in the data collection phase of this study. After revision of the forms, each medical student then spent a fortnight with two different general practitioners. During his stay with each physician, the student completed one form on each observation day, recording the time the physician began and ended each task and prepared a daily total of time spent in each category.

The ten physicians who participated in this time study were Maryland Academy of General Practice members who had indicated willingness to participate in a preceptorship program and in investigative studies of the Division of Family Medicine. Seven of these physicians were in urban and three in rural areas of Maryland. Four of the physicians were in solo and the others in partnership or group (three or more physicians) practice.

**Questionnaire Survey:** Following completion of the time study of physicians' office practice, a questionnaire was developed for distribution to all members of the Maryland Academy of General Practice. The questionnaire sought to obtain general information about the practice of each physician, and he was then asked to indicate whether certain procedures, activities, and tasks were performed in his office and if they were, whether each was performed by him or other office personnel. The physicians were also asked to indicate their interest in hiring a trained physician's assistant and to identify those tasks which they would delegate to this assistant. This section of the questionnaire identified those activities and procedures which were included in the office survey (Table 1) as well as the additional responsibilities listed in Table 2.

**Table 1: Categories of Procedures and Activities Included in the Time Study of General Practice**

- A. Physical Measurements
  - 1. T.P.R.

- 2. Height
- 3. Weight
- 4. Chest expansion
- 5. Other (specify)

**B. Syringe Procedures**

- 1. Venapuncture
- 2. Administration of tuberculosis test, etc.
- 3. Vaccination
- 4. Administration of subcutaneous or intravenous injections

**C. Patient Laboratory Procedures**

- 1. Tonometry
- 2. Audiometry
- 3. Vital capacity
- 4. Visual acuity
- 5. Electrocardiogram
- 6. Preparation of EKG record
- 7. Chest and other X-rays, including fluoroscopy
- 8. Developing X-ray
- 9. Test for color blindness

**D. Laboratory Tests**

- 1. C.B.C.
- 2. Urinalysis
- 3. Stool test for parasites and occult blood

**E. Bandages and Casts**

- 1. Application and removal of various types of bandages
- 2. Application and removal of extremity casts
- 3. Taping of chest or joint

**F. Therapy Procedures**

- 1. Removal of sutures
- 2. Syringing ears for removal of cerumen
- 3. Removal of splinters
- 4. Suture of superficial skin wound, excluding face
- 5. Throat culture
- 6. Application of anterior nasal pack
- 7. Catheterization of male patient
- 8. Ultrasound therapy

**G. Patient Instruction**

- 1. Instruction in preparation and understanding of diets
- 2. Instruction in the use of a syringe (diabetics, etc.)
- 3. Instruction of patient for preparation prior to certain diagnostic tests

**H. Paper Work**

- 1. Partial completion of insurance forms
- 2. Partial completion of health questionnaire

**Table 2: Additional Activities, Procedures, and Responsibilities Included in Questionnaire Survey**

- Record past history and system review
- Record present illness
- Record interval history
- Perform selected parts of physical examination
- Perform uncomplicated deliveries
- Perform routine prenatal check ups
- Make initial house calls for screening purposes
- Make routine visits to patients in nursing homes
- Management of certain cases (eg, diabetes, exogenous obesity, stable hypertension, etc.)



## Results

**Time Study of Physicians' Office Practice:** Direct observations were made for five or more days on the office practice of each of the ten physicians participating in the study (Table 3). This table also indicates the average amount of time spent per day by each physician in the eight activity categories, as well as the average time spent per day by all physicians (last column of table). The office prac-

tice of these physicians did vary with considerable differences noted between physicians in the amount of time spent in certain procedures. For example, physician A spent less than a minute a day on therapy procedures, while physician B spent over half an hour a day on such procedures; similar variations are noted between physicians in other categories of activities.

**Table 3: Average Amount of Time, In Minutes, Spent Per Day By General Practitioners In Various Office Activities**

Physician	A	B	C	D	E	F	G	H	I	J	Total
Number of Days Studied	5	5	5	7	5	10	5	8	10	5	10 65
Activity	Average Time in Minutes A Day										Average Time Spent Per Day By Physicians
Physical Measurements	5.0	14.6	7.4	2.7	18.8	14.1	12.2	6.8	6.0	7.2	9.5
Injection Procedures	0.2	6.0	5.0	1.3	15.6	12.6	14.0	4.5	0.1	11.2	7.1
Pt. Lab Procedures	0	6.4	0	0.6	2.4	0.4	0.6	0.1	0	0.4	1.1
Laboratory Tests	0	3.6	1.4	0.3	6.8	5.5	0	0.4	0.5	8.8	2.7
Bandages-Casts	2.6	20.8	5.2	0.7	2.6	2.5	1.6	3.9	4.6	18.6	6.3
Therapy Procedures	0.2	38.4	3.0	2.8	2.8	9.6	4.8	1.3	6.9	27.6	9.7
Patient Instruction	0	6.6	1.2	0.1	1.0	0.4	0.6	0.8	1.3	5.0	1.7
Paperwork	0	20.0	16.8	NR*	7.6	NR	6.4	NR	NR	0.8	5.2
All Activities	8.0	116.6	40.0	8.5	57.6	45.1	40.2	17.8	19.4	79.6	43.3

\*NR: Not Recorded

It was customary for some physicians to complete, at their homes, those paper work activities included in this observational study. This time was not estimated and no time is included in Table 3 for this category.

The average time spent by these physicians on all categories of activity was just over 43 minutes a day. This varied among the physicians from a daily average of eight minutes for physician A to almost two hours for physician B.

**Questionnaire Survey:** The questionnaire was mailed in October 1969 to 289 members of the Maryland Academy of General Practice. Replies were received from 221 or 73% of the Academy members. Forty-one of these questionnaires were not used in the analysis because these Academy members were either retired, working part-time or full-time in hospital emergency rooms, or working part-time or full-time in industrial medicine. Questionnaires were returned by 170 Academy members who were in full-time private practice and information provided by these physicians was analyzed.

**Physician and Practice Characteristics:** Seventy-seven percent of the 170 physicians were in solo practice and the rest in partnership or group practice. The physicians in solo practice had an average

of 2.5 office employees and those in group or partnership practice had an average of 7.8 office employees. Sixteen percent of the physicians were less than age 40 and 19% were age 60 or older. Forty-seven percent of the physicians had their practice in communities with a population of 50,000 or more, 26% of the physicians practiced in communities with less than 10,000 population, and 15% practiced in communities with less than 5,000.

The questionnaire identified some procedures which were not commonly performed by the physicians, and those not performed in the practices of at least 40% of the physicians are included in Table 4A. Many of the physicians reported that they regularly or occasionally assigned responsibility for certain procedures to other office personnel. Listed in Table 4B are those procedures which were occasionally or regularly assigned to other office employees by 30% or more of the physicians. It will be noted that complete blood counts were not done in the office of over 50% of these physicians (Table 4A), but when done were commonly assigned to other office personnel (Table 4B). Although ultrasound therapy was performed in the practice of the majority of these physicians (Table 4A), this therapy was commonly given by other office employees (Table 4B).



**Table 4A: Frequency of Certain Procedures Not Performed In Physician's Practice**  
M.A.G.P. Study (n = 170)

Procedure	Proportion of Physicians not Performing Procedure
Audiometry, Vital Capacity, Routine Deliveries	70-79
Chest X-ray, Long Bone X-rays	60-69
Tonometry, CBC, Prenatal Care	50-59
Application and Removal of Casts, Ultrasound Therapy	40-49

\*       \*       \*       \*       \*       \*       \*

**Table 4B: Proportion of Physicians Who Usually or Occasionally Assign Procedure to Other Office Personnel**  
M.A.G.P. Study (n = 170)

Procedure	Proportion of Physicians Regularly or Occasionally Assigning Procedure to Other Office Employee
Urinalysis	60-69
TPR, BP, Injections, Visual Acuity, Perform an EKG, Test Instructions	50-59
Skin Tests, Test for Color Blindness, Bandaging, Ultrasound Therapy, Syringe Instruction	40-49
Vaccination, CBC, Diet Instruction	30-39

In response to the question whether they would hire a trained physician's assistant, 40 physicians (23.5%) said yes, 121 (71.2%) said no, and nine physicians did not answer this question. Comparison of those physicians who were willing with those who were not willing to hire a physician's assistant

indicated that the former group included proportionately more physicians in partnership or group practice, fewer practicing in the smaller communities, fewer physicians over age 60, and proportionately more preferred to be called family physicians rather than general practitioners (Table 5).

**Table 5: Comparison of Physicians Who Indicate Willingness or Unwillingness to Hire A Physician's Assistant**

Characteristics	Physicians Willing to Hire a Physician's Assistant n = 40	Physicians Unwilling to Hire a Physician's Assistant n = 121
<b>Form of Practice</b>		
Solo	58%	83%
Group or partnership	43	18
<b>Location of Practice</b>		
Community with population <10,000	13	32
Community with population >50,000	51	47
<b>Age of Physician</b>		
<50	55	52
60+	11	19
<b>Preference for Family Physician as Specialty Title</b>	64	59

The two groups of physicians also differed in terms of their performance of certain office procedures and assignment of tasks to other employees. The questionnaire requested information on 38 tasks and procedures and the vast majority of these were performed more often by physicians willing than physicians unwilling to hire a trained assistant. For six procedures, there was a greater than 10% difference between the two groups of physicians; these procedures and tasks are listed in Table 6. With

one exception (vital capacity), the procedures were more commonly done in practices of physicians willing to hire a trained assistant. At the time of this survey, these physicians were also assigning to other employees more responsibility for the performance of certain procedures than were physicians who indicated unwillingness to hire a physician's assistant (Table 7). This table lists 14 procedures and responsibilities where there was at least a 10% difference between the two groups of physicians in the



assignment of duties to other office personnel. Fifteen additional procedures were identified which were more commonly assigned to other office personnel by physicians willing to hire a physician's assistant but the difference between the two groups was less than 10%. For only five of the 38 procedures or tasks included in the questionnaire were the physicians unwilling to hire a physician's assistant more often assigning responsibility to other office personnel.

**Table 6: Comparison Frequency, of Procedures Done In Office, Between Physicians Willing (Yes) and Unwilling (No) to Hire A Physician's Assistant, Differences Between Physician Groups Greater Than 10%**

Procedure	Proportion of Physicians who Perform Procedure in Office	
	"Yes" MD's	"No" MD's
1. Tonometry	53	41
2. Chest X-ray	41	29
3. Long bone X-rays	41	28
4. CBC	67	39
5. Application and removal of casts	69	54
6. Vital Capacity	11	24

**Table 7: Comparative Frequency of Procedures, Regularly or Occasionally Performed by Other Office Employees, According to Physician's Willingness (Yes) or Unwillingness (No) to Hire A Physician's Assistant**

Procedure	Proportion of Physicians Who Regularly or Occasionally Assign Procedure to Other Office Employee	
	"Yes" MD's	"No" MD's
1. Subcutaneous and intramuscular injections	66%	52%
2. Visual acuity	63	44
3. Color blindness	66	43
4. EKG	69	53
5. Chest X-ray	38	21
6. Long bone X-rays	32	22
7. CBC	53	26
8. Urinalysis	79	59
9. Bandages	54	44
10. Syringe	24	14
11. Throat culture	35	19
12. Ultrasound therapy	49	37
13. Instruction of patient for certain diagnostic tests	63	52
14. Record past history and system review	23	12

The physicians who indicated willingness to hire a physician's assistant were asked to identify the procedures and responsibilities which they would assign to this employee and the results are shown in Table 8. Over 90% of these physicians would assign to the physician's assistant responsibility for many of the procedures and activities included in Table 2. Over 80% of the physicians would give the assistant responsibility for recording present illness, past history, system review, for making home visits, and for a number of other patient procedures. Over 50% of the physicians would give responsibility to the physician's assistant for the management of certain patients with chronic medical problems, responsibility for suturing superficial wounds, providing routine prenatal care, and making screening house calls.

**Table 8: Procedures to be Performed by Physician's Assistants According to Proportion of Physicians Allowing Performance of Procedures n = 40**

	Allowed by % of MD's*
T.P.R., vena puncture, skin tests, vaccination, injections, audiometry, vital capacity, visual acuity, eye tests, EKG, CBC, urinalysis, bandages, throat culture, ultrasound therapy, diet instruction, syringe instruction, test instruction	90-100
Tonometry, chest X-ray, extremity X-ray, casts, taping, suture removal, syringe ears, remove splinters, catheterization, record present illness, past history, system review, and interval history, make nursing home visits	80-89
Anterior nasal pack, routine prenatal care, screening house call visits	70-79
Suture superficial wounds, selected parts of physical examination	60-69
Patient management	50-59
Perform routine deliveries	30-39

\* Adjusted to eliminate non-responses of some physicians on certain items

## Discussion

**Task Performance:** Direct observation of the office practice of the Maryland general practitioners revealed that an average of 43 minutes a day was spent in the performance of certain selected tasks and procedures. This amount of time is less than has been reported from observations of other practices. A somewhat similar study was completed by Parrish, et al,<sup>5</sup> who reported that 20% of the office time of Missouri general practitioners was spent in such treatment activities as applying or removing



bandages, suturing lacerations, setting fractures, injections, and so forth. These treatment activities took an average of 94 minutes a day for the Missouri physicians compared with 23 minutes daily for the Maryland physicians (Table 3). The Missouri study does not allow identification of physician time spent in the other categories included in this Maryland study (Table 1) but if it had been identified in the Missouri study, then more than 20% of these physicians' office time would have been spent in performing all these tasks and procedures.

The differences between the results of the Maryland and Missouri studies are probably accounted for by differences in the form and scope of practice between the two physician groups. All the Missouri physicians were in rural practice and often were the town's only physicians; in no instance was the Maryland physician the only practitioner in the town and only three of the ten Maryland physicians were in rural practice, one of whom was in partnership practice. In neither study was information available on the number and activities of other office employees in the physician's practice. Differences in the extent to which the physician assigned to others the responsibility for certain treatment procedures could also contribute to differences between the Maryland and the Missouri general practices.

It would appear therefore that a trained assistant could save considerable time for some physicians without performing "clinical tasks" such as physical examinations or obtaining patient histories. However, training for the performance of just these tasks and procedures would not be appropriate for an assistant working with the Maryland physicians included in this study.

**Task Delegation:** Physicians commonly employ other office workers to increase their productivity and extend patient services. The questionnaire survey of Maryland Academy of General Practice members revealed a marked variability among them in the delegation of tasks to other employees, but all reporting physicians delegated some of the designated tasks at least occasionally, and many physicians frequently assigned tasks to allied health workers. Similar findings have been reported by Yankauer, et al, from a survey of pediatric office practice by members of the American Academy of Pediatrics.<sup>6</sup> These pediatricians were delegating performance of many tasks to allied health workers and some of these tasks were the same as those included in our Maryland survey. In both surveys, a similar proportion of the physicians were assigning some task responsibilities to other office employees. In the pediatric practice survey, 68% of the physicians reported that other office workers did the urinalysis, 45% the blood count, 50% injections, 58% immunization, and 33% blood pressure recording.<sup>6</sup>

Approximately one fourth of the Maryland general practitioners indicated willingness to hire a physician's assistant, proportionately less than has been reported from other studies. Yankauer, et al, reported that at least two thirds of pediatricians indicated willingness to hire an allied health worker on full- or part-time basis to perform tasks and procedures then carried out by the pediatrician.<sup>6</sup> Coye and Hansen surveyed practicing physicians in Wisconsin and reported that 42% of the general practitioners indicated that they could use a trained physician's assistant.<sup>7</sup> Differences among specialty groups in willingness to hire a trained assistant is to be expected and it may well be that there are regional differences in the interest of general practitioners in hiring such trained personnel.

Other surveys have reported physician willingness to delegate procedures, tasks, and other clinical responsibilities to new allied health workers. In the Wisconsin study,<sup>7</sup> 70% of the general practitioners indicated that it would be appropriate for a physician's assistant to do preliminary histories, 23% would be willing to have this assistant perform some portions of the physical examination, 42% would delegate routine prenatal care, 38% well child care, and 25% would allow the physician's assistant to make limited house calls. A survey of pediatric practice in the United States<sup>6</sup> indicated that 75% of the pediatricians would favor delegation, to another trained office worker, of the recording of family and social history, 64% would delegate the past medical history, and 38% the history of present illness. Thirty-five percent of the pediatricians would delegate examinations of the well child and 19% would delegate responsibility for some examination of the sick child.

The higher proportion of Maryland physicians willing to delegate these tasks and responsibilities (Table 8) is probably due to the limitation in our questionnaire of these questions to physicians who indicated willingness to hire a trained assistant.

Direct observation of physician's practice and the questionnaire survey have provided information which is useful in planning educational programs for new health workers in the office practice of Maryland physicians. Variability in task performance was found among these general practitioners and those interested in hiring a trained assistant were delegating more responsibilities to other office employees. The differences noted in task performance by practitioners in different states, as well as the differences reported in physician interest in hiring a trained assistant, suggest that similar surveys would be of value in other areas prior to the development of new training programs.

Physician interest in hiring an assistant is learned from responses to questions which may or may not mention the possibility of part-time employment.



Current training programs for physician's assistants are being developed for individuals who would be working full-time in this new role. Although a trained assistant might work part-time for two or more physicians, it seems unlikely that the current training programs would fill the expressed need of part-time workers in physicians' offices. Since many physicians are currently delegating a variety of tasks to other office employees, it might be of value to consider increasing their capabilities by providing short term special training or continuing education programs. For example, the physician's office nurse might be sent to a training center for one or a series of short courses so that she would be competent to perform those tasks and assume those responsibilities which are of most concern to that physician in increasing his service to patients. Studies are currently underway in the Division of Family Medicine to explore physician interest in the development of continuing education or special training programs for their office employees.

### Summary

The office practice of ten Maryland general practitioners was observed for at least five days each.

These physicians spent an average of 43 minutes a day performing certain technical and treatment activities which might readily be performed by a trained physician's assistant.

A questionnaire completed by members of the Maryland Academy of General Practice revealed that many of these physicians were assigning to other office employees responsibility for performance of a number of patient-related tasks. Approximately one fourth of the Maryland Academy members expressed interest in hiring a trained physician's assistant. As a group, these physicians tended to be younger than those not interested in hiring a trained assistant and also fewer were in solo practice or in small communities. Physicians willing to hire a trained assistant would also assign considerable responsibilities to this new office assistant, including a variety of therapy procedures, the recording of patient histories, performance of selected parts of the physical examination, and the management of patients with stable medical problems.

Direct studies of physician practice as well as questionnaire surveys are of value in planning training programs for allied health professionals working full-time or part-time in physicians' offices.

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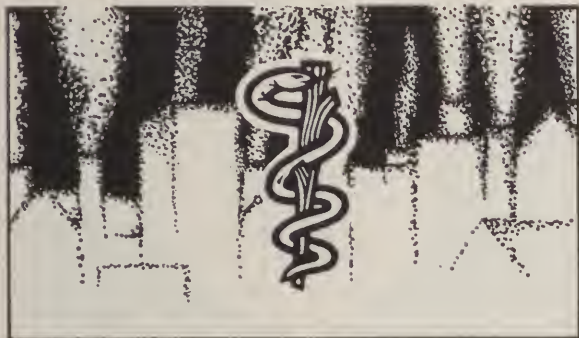
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**occupational and  
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## How to Diagnose Occupational Disease

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**By definition and by statute, an occupational disease must arise out of and occur in the course of employment, and it must be due to the nature of the occupation or process. This rules out conditions common to a neighborhood, area, or geographical location. It rules out illness which may occur at home or on the job and it rules out most diseases which are inherited.**

Occupational medicine had its beginning with the first working man, with the beginnings of medicine, with the knowledge that workers are exposed to all types of physical and mental hazards and to newly developed toxic materials and their by-products.

Occupational medical problems are generally not understood by the practicing physician, for he has little knowledge of his patient's working environment. Nor is he made aware of the specialty during the informative years in medical school. How often is an occupational disease discussed during staff conferences? How many physicians read journals or textbooks which deal mainly with the diseases of occupation? How many hospitals offer consultative services in occupational medicine for the medical staff?

Many physicians feel that a scientific basis is not necessary for the diagnosis of occupational disease. It is surprising how many practitioners look upon basophilic stippling as the sole laboratory procedure to establish a diagnosis of lead poisoning. They fail to realize that they probably are the first to see a

subclinical case of lead poisoning and that blood and urinary lead determinations will often make the diagnosis.

Because of many pressures, the family physician does not take time for an adequate history, nor does he do a complete examination with X-ray and laboratory tests to rule out various causes of symptom complexes.

Sometimes he goes out of his way to convince his patient that his difficulty is occupational in origin because he does not have the time or the inclination to make a proper diagnosis. A diagnosis of occupational dermatitis is "obvious," since his patient is exposed to "chemicals" during his eight-hour working day. But what of the other 16 hours when he is exposed to all sorts of irritative contactants? How easy it is to convince a patient that he has "steel poisoning" when the physician is faced with a pulmonary infection of unknown etiology or he cannot explain unidentified pulmonary markings, particularly when his patient works in a steel plant. How often has a physician explained low back pain



to his patient as follows: "If pain ensues while a man is cutting his own lawn, the term 'lumbago' is invariably applied and the condition is attributed to causes within the man, but pain arising while stooping, bending, or lifting at the plant is called 'back sprain' and is considered the result of motion while working for someone else".

It has often been said in clinical medicine that a good history is the most important factor in arriving at a diagnosis. This fact is of equal or greater importance in the occupational history. Nowhere is detail more important. Merely asking the patient to recite each job he held, or the name of the company he worked for since leaving school is a waste of time. If a patient tells you he is a sandblaster, do not be content to call certain shadows on a chest film silicosis. Not all abrasive blasting is done with sand and not all sand (silica) plus X-ray equal silicosis.

Job titles may be deceiving. Find out specifically what a patient is exposed to and for how long. Find out what his past exposures have been. It is most important to find out what his environmental exposures have been away from work. If you had a case of some blood dyscrasia, like leukemia, occurring in a telephone operator, would you be satisfied that the occupation was not contributory? If you had elicited a history that your patient worked in a tiny room without ventilation, that on arrival in the morning she would clean the switchboard with benzol, that she did this daily for ten years, would you not then be satisfied that her marrow findings were compatible with benzol poisoning?

Along with history taking is the important knowledge that some occupational diseases have long latent periods between the time of exposure and the appearance of symptoms. Examples of these are ionizing radiation, silicosis and other dust-producing pneumoconioses, and cancer-producing agents. The presence or absence of a similar disease in associates, at home, or at work is often very helpful in making a diagnosis.

Along with a detailed history, it is important to determine specific substances handled, the intensity and duration of exposure, the type and condition of protective clothing and devices worn. It is also important to evaluate physical agents such as radiation, heat, cold, and noise and their effect on the individual patient and his fellow workers.

The physical examination must be complete and detailed. Certain exposures have an affinity for a particular organ or part of the body and these may be easier to identify. A worker in the chrome industry complained of blood streaked sputum. Examination of the chest and X-rays were negative. The physician overlooked a perforated nasal septum.

Routine laboratory tests—such as complete urinalysis, CBC, serology and chemical determinations—

are always in order. Kidney function and liver function studies add to the physician's diagnostic fund of information, necessary to detect early changes. Radioisotopes are being used to detect tissue deposition of toxic substances. Sputum examinations, lung biopsies, gross and microscopic examinations, lung ashing and chemical determinations, chromatography and petrography are all tools used in diagnosis. Routine X-rays and specialized scanning techniques are being used to isolate pulmonary infiltrations. Transistorized noise dosimeters attached to the working man have been used to determine how long he has been exposed to various noise levels. Electrocardiographic instruments are worn by the worker throughout the day and night to determine the effect of physical, chemical and mental exposures on the heart and lungs.

New tests are constantly being devised to aid in the "monitoring of man". Of major importance is the development of a simple blood test that permits detection of workers hypersusceptible to blood-destroying chemicals. The test is a visual methemoglobin reduction test and permits screening of workers and placement in jobs where harmful effects will not occur. Another important determination is the blood cholinesterase in cases of organic phosphate ester insecticide exposure.

The physician should think twice before he makes a positive statement that a certain disease is occupational in origin. Physicians in industry will be only too happy to help if the occupation is suspect. If the industry is small and personnel people are not cooperative, then the occupational disease sections of the city and state health departments are most cooperative in tracking suspected cases. Another agency that is most helpful is the Occupational Health Section of the U.S. Public Health Service. The physician must also become familiar with the specific Workmen's Compensation Act dealing with occupational diseases.

In summary, patients regularly consult physicians with signs and symptoms of definite as well as indefinite character. When these stem from the patient's occupation and when the physician's knowledge, interest, and astuteness lead him to suspect the occupation, many obscure diagnostic challenges can be brought to light. There are four cardinal points in making a diagnosis of occupational disease:

- (1) History taking must be exact, meticulous and in detail.
- (2) The nature, extent and severity of the exposure must be known and corroborated by experts in the field.
- (3) Signs and symptoms must fit specific diagnostic patterns.
- (4) Clinical and laboratory tests must tie in with the three factors mentioned above.





NEIL SOLOMON, MD, PhD, SECRETARY

## Maryland State department of health and mental hygiene

### Toxoplasmosis

KENNETH L. CRAWFORD, DVM, Chief  
Division of Veterinary Medicine  
Maryland State Department of  
Health and Mental Hygiene

Toxoplasmosis is an ubiquitous protozoan disease found in all human populations, in all orders of mammals, in birds, and some reptiles. *Toxoplasma gondii*, the etiological agent, is believed to be one species lacking host and cellular specificity. Since toxoplasmosis is a nonreportable disease in man and animals, a reliable estimate of its incidence is unavailable. However, numerous serological and skin testing surveys on various populations indicate a prevalence rate in the human population of the United States to vary from less than 1% to about 30%.

A geographic variation is evident with the Appalachian region having the highest prevalence. Prevalence increases with age up to 40 years, when a plateauing effect is evident. Based on testing, it is estimated that 30% of Maryland residents have experienced a toxoplasma infection.

Serological surveys of animals have yielded similar results to the human studies.

Many cases of human toxoplasmosis are clinically inapparent. Symptomatic toxoplasmosis can occur with the congenital form being the most serious. Toxoplasmosis in humans is recognized as a significant cause of perinatal mortality with abortion and stillbirth common sequelae of the disease. The three major categories of the clinical disease in man are:

1. Congenital—Usually characterized by hydrocephalus, cerebral calcification, and chorioretinitis.
2. Acute—Similar to infectious mononucleosis; characterized by lymphadenopathy, fever, hepatosplenomegaly, malaise, and sometimes a rash. An estimated 5% to 10% of undiagnosed lymphadenopathy cases result from a *Toxoplasma* infection.
3. Chronic—Usually evidenced by an acute flare-up of chorioretinitis. Approximately 30% to 40% of the granulomatous chorioretinitis cases are due to toxoplasmosis.

Toxoplasmosis in man and animals often occurs as a subclinical infection. When illness results, a characteristic syndrome is absent. For example, toxoplasmosis in dogs can be confused with distemper and it can also accompany distemper. Positive diagnosis requires a biopsy, isolation of the organism or serological testing. The available skin test in

animals is of questionable value.

The only proven mode of transmission is transplacental in man and animals. Man-to-man transmission has not been established. Since close association of man and animals is common, studies of animals have been made. These seem to indicate an association between the amount of animal contact and the rates of toxoplasmosis in man, but a responsible species has not been established. A variety of modes of transfer has been postulated including respiratory conjunctival, ingestion of meat, milk or feces, and arthropods. However, none of these alone explain the widespread infections.

Recent work indicates that *T. gondii* is a coccidian of cats which is morphologically related to *Isospora bigemina*. Initially, it was postulated that *Toxocara cati* served as the natural reservoir and mechanism of transmission for the fragile trophozoite (vegetative phase) of *T. gondii*. However, a newly discovered fecal cyst (oocyst) of *T. gondii* that is resistant to adverse environmental conditions brought into question the theory of a nematode vehicle. Subsequently, experiments have shown that transmission of *T. gondii* from cat-to-cat can occur in cats free of *Toxocara cati*—thereby demonstrating that nematode mechanism is not essential. The testing of 12 other species of mammals and birds for their capacity to excrete *Toxoplasma* oocysts has thus far yielded negative results. It is now postulated that a life cycle exists in which oocysts are the original vehicle of transmission from cat-to-cat. It is theorized that the parasite can multiply and persist in the cyst stage in a variety of tissues and hosts. Thus, carnivorousness becomes an additional means of trans-



mission. Since cats are the only species where excretion of oocysts has been demonstrated, it has been postulated that cats are the primary host and other animals, including man, are intermediate hosts.

Toxoplasmosis is considered to be a zoonotic disease although direct evidence of animal-to-man transmission is lacking. Veterinary clinicians should reduce the possibility of transmission of toxoplasmosis from animal-to-man by:

1. Practicing suitable established standards of sanitation.

- a. Advising young children and their parents and pregnant women to avoid contact with infected animals and their environment.

- b. Carefully removing and properly disposing of products of abortion excreta and other animal products and then suitably sanitizing the area.

- c. Eliminating endo- and ectoparasites.

2. Isolating infected animals.

3. Treating infected animals. There are advocates of euthanasia of infected animals to remove the potential of disease transmission. The practice may not be warranted since direct evidence of transmission from animal-to-man or animal-to-animal except for transplacental is presently lacking.

#### Significance of Serologic Data in Toxoplasmosis\*

Antibody responses in toxoplasmosis can be detected by four different methods: 1. Indirect fluorescent antibody test (IFA), 2. Indirect hemagglutination test (IHA), 3. Complement-fixation test (CF), and 4. Sabin-Feldmann dye test. Because of the complexity of the dye test, it is not routinely available.

In primary infections with toxoplasma there is a rapid rise in IHA, IFA and dye test antibodies usually with one to two weeks postinfection to titers of 1:256 or greater. Peak titers are reached usually by the third or fourth week. These antibodies persist at high levels for several years and then gradually decline to low levels (1:16 to 1:128) which tend to persist indefinitely. CF antibody usually is not detectable until about the third or fourth week of infection and then rises to a titer ranging from 1:16 to 1:256 in about two months. CF antibody then begins to decline and may disappear completely within two to three years. In some individuals it may persist at a low level for several years.

In acute human illness, dye test antibodies are the first to appear. IHA antibodies appear a few days later and rise more slowly but attain similar or higher

titers and persist for many years. FA antibodies parallel dye test antibodies but titers are lower.

Antibodies detectable in any of the above tests can pass through the placenta from mother to fetus and can be found in equivalent titers in the newborn. If the infant is not infected, these antibodies will disappear from the serum of the child within four to six months. In congenital toxoplasmosis, the antibody titer will remain elevated after four months of age.

Adult antibody titers for the Indirect Fluorescent Antibody test (IFA) and the Indirect Hemagglutination test (IHA) for toxoplasmosis should be interpreted as follows:

#### Reciprocal of Titers

IFA	IHA	
16-64	64-128	(Found in up to 30% of normal population) Usually indicates a past exposure but may mean an early stage of the disease which can be determined by testing additional blood specimens.
128-256	256	(Found in approximately 10% of normal population) Indicates fairly recent exposure and should alert the physician. Additional blood specimens should be tested for further rise in titer.
512-1024+	512 or greater	(Found in less than 5% of the normal population) These high titers should be seriously considered as indicative of very recent or current infection with toxoplasma.

The CF test is useful in establishing an early or congenital disease; CF antibody titers are lower than the IFA or IHA and disappear sooner. If a mother has a high antibody titer to both the CF and one of the above tests, and the infant has a high IFA or IHA titer but has no CF antibody, the results are indicative of congenital toxoplasmosis. Occasionally, in children less than one year of age, high IFA titers are found in the absence of IHA antibody and CF antibody.

These tests are highly specific for toxoplasmosis and any level of antibody indicates exposure to the agent.

The IFA test is as sensitive as the methylene blue dye test (Sabin and Feldmann) and the IFA is more reproducible.

In problem cases, 19S and 7S antibody determination are available.

\* Source: Bureau of Laboratories, Maryland State Department of Health and Mental Hygiene.



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Belladonna result chiefly from  
their Atropine content . . .  
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS  
3rd Edition, page 522



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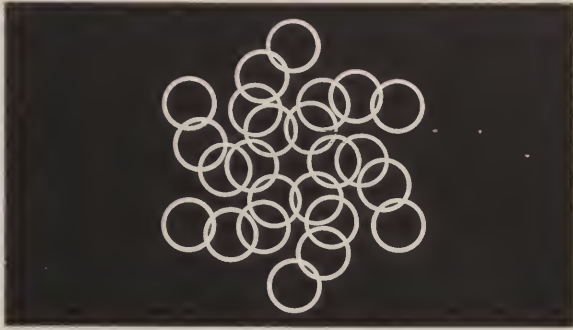
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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# An Example of Alcoholism Treatment in the United States

**WILLEM G. A. BOSMA, MD**  
Director of Alcoholism Programs  
University of Maryland Hospital  
Baltimore

The United States always claims the superlatives of "bigger and better." Lately however, Americans seem to have changed. *The New York Times* recently carried an article implicating that American tourists are popular abroad lately, because of their friendly and unassuming attitudes. They are becoming aware that there are some cracks in the "melting pot." One of the slogans one hears frequently now is, "smaller and less is better." I am sure I will reflect some of the old American attitudes, however, just because of my pride in the state of Maryland and especially in the University of Maryland.

In order to discuss current alcoholism treatment, it is necessary to look briefly at the history of alcoholism in the United States. The alcoholic was, until very recently, regarded as a moral deviant, a person unable to control himself or his impulses. In 1917, the United States tried the ultimate in alcohol control by passing the 18th Amendment to the Constitution. This outlawed the sale of alcoholic beverages in the United States. However, neither drinking nor alcoholism disappeared, as had been expected by the reformers, and the people of the United States had only been deprived of their legitimate right to drink. So by 1936, all but eight states again permitted the manufacture and sale of alcoholic beverages. The prohibition era in the United States is a lesson in the futility of dealing with alcohol use and abuse in a legally suppressive manner. Obviously, imprisonment has proved not to be a deterrent to public drunkenness.

*This paper was presented at the First British International Conference On Alcoholism and Drug Dependence on April 1, 1971 in Liverpool, England.*

Much more important to us, however, is the year 1936, when two people with an alcoholic problem, after looking in vain for help from physicians and other professionals, started their own program for sobriety which they called Alcoholics Anonymous. This was the beginning of a necessary change in the treatment of alcoholism. While Alcoholics Anonymous groups sprang up all over the country, 20 years passed before some members of the helping professions started looking at alcoholism as a disease and alcoholics as people in need of treatment.

The American Medical Association declared alcoholism to be a disease in 1956. Last year, finally, the Congress enacted a law, officially called the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970. It created a National Institute of Alcohol Abuse and Alcoholism within the Department of Health, Education and Welfare, which started the attack on the problem of alcoholism with sizable monies appropriated. The measure includes a strongly-worded Bill of Rights for alcoholics, not only for their treat-



ment by federal agencies, but also on state and local levels and, even further, in private industry and hospitals providing a sanction withdrawal of federal funds.

A federal law passed by Congress in Washington is often intended as a prototype for similar laws in the individual states. A federal law in such an area as alcoholism control depends on the good will and active cooperation of the states to implement it. Thus, alcoholism services throughout the United States are very uneven.

### New Approach to Treatment

In 1968, the Maryland legislature passed the first Comprehensive Intoxication and Alcoholism Control Law in the whole country; the state now has the most advanced and imaginative statewide treatment program in the United States.

You may be wondering about my preoccupation with the law and its involvement with alcoholism. My esteem for the influence of laws on modification of behavior has risen tremendously, that is, when the laws are humanitarian in their intent. Both the so-called civil rights laws of the 1960's and now the law on alcoholism have given impetus to the humane treatment of people heretofore harassed and regarded as second-rate citizens.

The law in Maryland hopes to effect three basic changes in the treatment of alcoholics. Implicit in the law is, of course, the idea that alcoholism is a medical problem: Alcoholics are sick people. The first major step then, is to take the care of alcoholics out of the hands of law-enforcement agencies.

First, alcoholism has to be *fully* accepted as a public health problem and not, as hitherto, primarily a law enforcement responsibility. Traditionally, across the state, some considerable percentages of alcoholics have been managed by law enforcement and correctional agencies and institutions. A study conducted in Maryland in 1965 indicated that as many as 25,000 (one eighth of the state's estimated number of alcoholics) had been so managed. A positive, comprehensive alcoholism program *must* begin by replacing that old system of management by a different, more productive system under health and social service direction.

Progress has been made in the past two years to implement this fundamental tenet, albeit unevenly across the state, and in no case reaching the final goal. On the credit side, local health department alcoholism coordinators in Baltimore city and in 22 of the 23 counties have worked closely with law officers, courts, and jails counseling and treating law-breaking alcoholics, in some cases probated to them. In one county, the health department provides counselors and vans on call to pick up "public drunks". In another, health department counselors have been

deputized as sheriffs and are gradually beginning to take over the old police function.

Furthest advanced toward the law's requirement to phase out police involvement with alcoholics are a little rural county and Baltimore city. In the former, the health department has established a truly comprehensive program, utilizing both public and private resources, and there has been a radical and welcome break not only in the age-old tradition of police management of inebriates, but also in the 30-year-old tradition of sending *all* alcoholics to the state mental hospital.

In Baltimore city, as a result of the health department's vigorous and enlightened leadership toward providing a broad range of services to alcoholics, police involvement with public inebriates has been reduced by about 65% from its 1965 level. The Baltimore Area Council on Alcoholism contributed to the trend by administering a transportation project (February 1969 to February 1970: 1,038 transported) to relieve Baltimore police from providing taxi service for alcoholics to and from the state hospitals—a project now transferred to the Department of Mental Hygiene and expanded to include all state hospital admissions.

The second desired change in treatment is for the care of alcoholics to be taken out of the state mental hospitals. For 30 years, the state mental hospitals have been the major, almost the only treatment resource for Maryland's alcoholics, a patient load they are not equipped to handle.

Because alcoholism is a massive *community* problem, alcoholism programming must emphasize decentralized, local, community service, and deemphasize state control and institutionalization; the alcoholic must be treated where he lives and works, preferably as an outpatient.

Alcoholics can and should be treated in the mainstream of health and social welfare, along with other sick and troubled people, and specialized services should be limited to those not already provided by existing health and social agencies.

Leadership for alcoholism programming should properly be a function of the local health department, and full-time specialized personnel should be added to the local health department staff. In Maryland, every local health department except one has such specialized personnel.

Every community mental health center and neighborhood health center must make its full range of services available to alcoholics, preferably by addition of alcoholism counselors to its staff. In its two-year-old community mental health program, the Maryland Department of Mental Hygiene has given top priority to integration of services to alcoholics within the state's burgeoning centers. The Alcoholism Counselor Training Program of the Baltimore City Health Department, which has graduated 98



trained counselors, has accelerated the process by assigning trainees to a number of centers for field experience, thus demonstrating the value of such nonprofessional personnel.

The Fellowship of Alcoholics Anonymous and Al-Anon Family groups have so ably demonstrated the value of dedicated nonprofessional help to sick alcoholics and their families: Services to alcoholics in both general and specialized agencies can and should be provided by nonprofessionals, with little or no drain on the professional market.

The fellowships continue to be the single most important resource in the alcoholism field, but public health programs are needed for functions the fellowship neither can nor should carry: for case finding and early diagnosis, for example; for social management of alcoholics already totally bankrupt physically, mentally, spiritually, economically, and socially; for medical and nursing care for the alcoholic in crisis; for professional training and for research.

Different as the alcoholism program of the local health department is from the program of Alcoholics Anonymous, it is no coincidence that of the 19 individuals employed by the health departments as program coordinators, all but five are themselves alcoholics who owe their recovery to Alcoholics Anonymous. The same ratio holds for the scores of alcoholism counselors now in the field.

Thirdly, because it is clear that public and private "helping people" are *not* presently prepared to help alcoholics and their families, and that most of them are indeed uninformed or misinformed about alcoholism and its victims, top priority in the Maryland program is given to (1) preparing them by educational programs to take on their respective responsibilities; and (2) introducing alcoholism content into the curricula of all professional schools.

### **Establishing Effective Alcoholism Programs**

In the history of almost every alcoholic are accounts of periodic searches for help, of desperate appeals to physicians, hospitals, clergymen, teachers, and others, and of meeting with rejection. To prevent such breakdown of understanding, alcoholism programs must work to correct the ignorance and prejudice of professional workers when dealing with alcoholics, and give them expert advice to aid alcoholics, so that the latter can find what they need when they need it.

If all the thousands of people such as physicians, nurses, and social workers who make their living in the helping professions were prepared to identify and help alcoholic individuals and families, there would be no "hidden alcoholics". In the classic case, for example, of the suburban housewife, her alcoholism, no matter how hard she tries to conceal it, should be recognized by her family physician, or

by her children's pediatrician, or by her clergyman, any one of whom should be able to penetrate her defenses and involve her in treatment.

For the last year, I have been working to develop an interdisciplinary curriculum on Alcoholism and Drug Abuse for the six postgraduate professional schools of the University of Maryland: the Schools of Medicine, Social Work, Law, Nursing, Dentistry, and Pharmacy. This is the first major effort in the U.S.A. to introduce alcoholism content courses into professional schools. The attitude of the students to the seminars and field work we offer has been most favorable, but the administrations have often been reluctant, even hostile. The latter reflect all the attitudes of professional people and society at large—attitudes which we have to change if alcoholics are to get the care they deserve.

You will agree that such a turnabout in attitudes presents a major challenge to professional institutions. Much has been done since enactment of the 1968 law, but even more needs to be done. Our difficulties have been compounded by the fact that only limited funds have been made available by the state of Maryland. The people of the Division of Alcoholism Control have had to concentrate on getting the cooperation of existing health and social facilities. When these have been insufficient, limited new ones have been established, mainly a variety of residential facilities for alcoholics.

### **University Hospital's Treatment Program**

An existing health facility that has been pressed into the service of providing treatment for alcoholics is University Hospital in Baltimore. This is a 600-bed facility which is not only a service but also a teaching hospital, associated with the University of Maryland. It treats patients from all walks of life.

The basic attitude at the hospital is that treatment processes with the highest incidence of success are those that tailor treatment to the individual needs and resources of the alcoholic patient. Thus, an alcoholic is met in the emergency room by a counselor who acts as a screening agent. Together with the physician on call, he decides where the patient will go for treatment. Some need to go to medical, surgical, psychiatric, or other specialized services, but while on these services, they are also seen by alcoholism counselors. If the patient does not require any service within the hospital, and has no home to go to, or is too sick to go home but not sick enough for the hospital itself, he can be referred to the Quarterway House. This resident facility is five minutes from the hospital and all the services of the hospital are available. Physicians make weekly rounds in this 20-bed facility. The average cost per alcoholic is \$5 a day as opposed to \$70 a day in a hospital.



In the Quarterway House, the alcoholic is first detoxified and if necessary, made comfortable with some mild tranquilizers. He is then actively involved in a program of education, personal and group counseling, therapy, and vocational rehabilitation. Families and relatives are, whenever possible, involved in the treatment program. The pros and cons of disulfiram and Antabuse are presented to him. Many choose this as an adjunct to staying sober.

The alcoholic stays two weeks in the Quarterway House. He is then referred to the outpatient clinic at University Hospital, and if he is on Antabuse, he is referred to the Antabuse Group, which meets weekly in the Quarterway House. Two alcoholism counselors make regular home visits and help the patient avail himself of treatment facilities in his neighborhood.

### Other Treatment Facilities

If the patient is well enough after having been seen in the emergency room of the hospital, where he sometimes stays up to 24 hours, he can be sent home. From there an effort is made to involve him in the various treatment facilities in his neighborhood, such as open or closed AA groups, outpatient psychiatric services, personal counseling, or after-care clinics.

If a patient has nowhere to go he can be referred to the Shelter, a 50-bed facility. The Shelter takes skid-row alcoholics and provides them with a bed, a meal, and some counseling. Patients do not have to stop drinking however, but the program does seem to reduce the amount they drink. This facility, for what we call the "chronic alcoholic", is a most helpful one. Previously, the chronic alcoholic has been referred to other agencies, where the assumption was that he would stop drinking. Neither party benefitted from such an arrangement and this rather hopeless patient tended to "clog-up" the facilities so much needed for patients with better prospects.

The Halfway Houses are for recovered alcoholics with jobs who need an interim supportive environ-

ment until they are able to go out on their own. Halfway Houses are self-supporting, as the patient pays room and board.

### Conclusion

It is clear that treatment facilities (and this applies to all large-scale programs in the United States) are still based on rather ineffective treatment modalities. Only 35% to 50% of the patients benefit from them. In fact, there is still no definite treatment for alcoholism. Individual or group psychotherapy, counseling, Antabuse, and membership in Alcoholics Anonymous are still regarded as the only hope for recovery.

In the meantime, many clinicians are desperately seeking more successful treatment methods, including conditioning and the use of LSD; up until now, without success. It is clear that we still have a long way to go in the treatment of what is considered America's number one health problem.

I would like to stress the three points that we in Maryland feel are necessary for the development of adequate treatment for the alcoholic:

- (1) Take the care and treatment of alcoholics out of the hands of law enforcement as much as possible.
- (2) Transfer treatment of alcoholics from the old and old-fashioned state hospital to a decentralized, local community service, preferably on an outpatient basis.
- (3) Prepare the helping professions, physicians, nurses, social workers, clergymen, etc., through educational programs to assume their respective responsibilities towards alcoholism and addiction to other drugs. Content on addiction to alcohol and other drugs should be introduced into the curricula of all professional schools, preferably on an interdisciplinary basis, as these professions will have to learn to help *together* with a problem that needs help from all areas.

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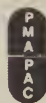




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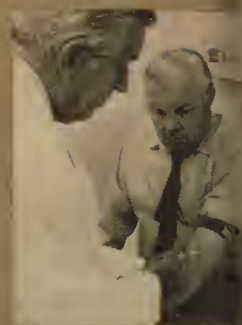


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- Thereafter** Continue effective DBI-TD dosage.

**To transfer from sulfonylurea therapy to DBI-TD alone:** The first week, withdraw sulfonylurea; start with DBI-TD as indicated in the chart.

**To transfer from sulfonylurea therapy to combined therapy with DBI-TD:** The first week, continue dosage of sulfonylurea; add DBI-TD as indicated in the chart. When effective regulation of diabetes is attained, sulfonylurea may be reduced and/or withdrawn.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions:** **Starvation Ketosis**, which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. **DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS.** **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones

in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331.** **Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.



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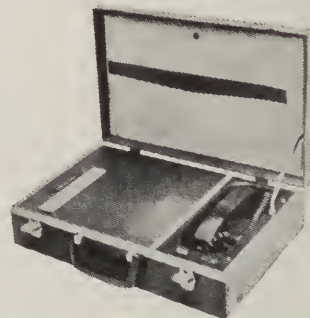


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FREDERICK J. BALSAM, MD, EDITOR

## **rehabilitation medicine**

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# **Electrodiagnosis: Essential for Accurate Neurological Diagnosis**

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Just as in the past, there is no substitute for sound clinical judgment based on keen observation and application of acquired knowledge and experience to arrive at a proper diagnosis. In spite of that, however, the advancement in modern technology has given us means to improve our accuracy when skillfully applying proper methods. Many of the now routine laboratory investigations of chemical and electrical phenomena in body tissues and fluids have surely widened our horizons; and adequate knowledge of their application, followed by critical interpretation, assures the sophistication of an expert opinion.

As the evaluation of muscle strength, range of motion, and functional ability is the basis of a physi-  
atric examination, electromyography and electro-  
diagnosis have added great dimensions in diagnostic  
assistance to neurologist, neurosurgeon, surgeon,  
and internist.

While there is much value in confirming already  
clinically diagnosed disorders and studying their  
characteristic behavior, it is the purpose of this  
communication to stress the importance of the use  
of electrodiagnosis where other methods of investiga-  
tion fail to provide the necessary information for  
a definitive diagnosis, or prognosis, or both.

The speed with which an impulse is conducted

along a nerve fiber is dependent on the fiber diam-  
eter and whether axon, and especially myelinsheath,  
are intact. Any disease interfering with its integrity  
will change the effective nerve conduction.

**1. Peripheral neuropathies:** Most of the patients  
seen with such disorders will have clinical evidence  
of sensory impairment, reflex changes or muscle  
weakness, or both, permitting proper diagnosis on  
clinical grounds. However, early in the course,  
changes in sensory nerve fibers may cause disturb-  
ing paresthesias to the patient at a time when even  
an expert neurological examination may not detect  
any objective abnormality. This occurs frequently  
in nutritional deficiencies, metabolic, or toxic dis-



case states. In these patients, while conduction times in motor and sensory fibers may still be normal, because of mainly axonal changes, there is diminution of the amplitude in the evoked sensory nerve action potential, and often an increase in current threshold may be noticed. As a disease process causes greater involvement of the myelinsheath, a drop in conduction velocity is noted. This may be quite pronounced, locally in compression syndromes, and more generally in ascending polyradiculoneuritis (Guillain Barré syndrome), peroneal muscular atrophy (Charcot-Marie-Tooth disease), or after chronic exposure to certain specific toxins.

**2. Compression syndromes:** The most common and often easily diagnosable compression syndromes are median nerve compression at the wrist and ulnar nerve compression at the elbow. Often, however, it is difficult to definitely rule out a C-7 lesion in a carpal tunnel and a C-8 lesion in a tardy ulnar palsy or thoracic outlet syndrome. It is interesting to note that the presenting complaint may differ, particularly in median nerve compression. One group will be most incapacitated by the motor weakness in opponens pollicis and abductor pollicis brevis. The patient may learn to compensate for the atrophied muscle by using ulnar innervated flexor pollicis brevis and radial innervated abductor pollicis longus, becoming so functional that the diagnosis of carpal tunnel compression is made incidentally when he is examined for other reasons. His motor latency may be up to ten milliseconds from wrist to thenar eminence (normal 2.5 to 4.5 msec), without detectible sensory response in the median nerve at the finger.

In contrast to this, the complaint may be largely sensory in the patient who seeks the physician's help at a time when motor latency may be still within the norm, but distal sensory conduction will be impaired, showing latencies above 3 msec measured from onset of stimulus to first deflection (normal 2.2 to 2.9 msec). Amplitudes are relatively well preserved. This may be very confusing if one places major emphasis on *motor* conduction: surgery in these patients is definitely indicated, even though many people with much greater objective involvement seem to progress without any treatment. Early surgery to relieve compression, at a time when there is only neuropraxia, will prevent axonal damage. To properly measure ulnar nerve conduction across the elbow in order to prove compression in the ulnar groove may present some technical problems; however, if carefully studied and combined with electromyography, the diagnosis can mostly be established.

**3. Guillain Barré syndrome and Charcot-Marie-Tooth disease; Dyskalemic paralysis:** The very pronounced slowing of nerve conduction found in Guillain Barré syndrome is quite helpful in diagnosing the less typical case presenting with disturbing sensory complaints and less noticeable motor changes.

There may be no definite objective abnormality, or inconclusive signs only. In my own experience, I have seen patients under psychiatric care, even admitted to a mental institution, before the diagnosis of an organic disease was made by electrodiagnosis and then confirmed by the clinical course.

Charcot-Marie-Tooth disease can usually be diagnosed clinically, especially if there is a family history of other members involved with the same disease. For genetic study and counseling it is important to recognize that frequently family members who do not present with any neuromuscular deficit on clinical examination may show marked slowing of nerve conduction, proving their subclinical involvement.

In Dyskalemic paralysis, family history may be the best help in diagnosis; but if not available, there may at times be confusion with "Drop-Attacks" secondary to brainstem ischemia. In the acute phase, nerve excitability may be completely abolished or lowered, returning to normal after attack. There are also frequently myogenic type EMG changes. Examination, of course, should be accompanied by serum potassium studies.

Another group of diseases where the site of pathology is mainly the myelinsheath rather than the axon, therefore presenting with very slow conduction velocities, are: Hypertrophic polyneuritis (Dejerine-Sottas), Refsum's disease, Metachromatic leukodystrophy and Globoid leukodystrophy (Krabbe's disease).<sup>1</sup> These are uncommon and mostly show other clinical characteristics rendering nerve conduction studies unnecessary, or using them for confirmation. In Krabbe's disease, however, nerve conduction studies may be indicated to help establish the presence of a peripheral neuropathy at a time when it is not clinically apparent because of hyperreflexia related to central nervous system demyelination.

**4. Bell's palsy:** An important aid in prognostication is the study of nerve conduction and electromyography in facial nerve palsy of unknown etiology. Even in clinically apparent complete loss of function of all muscles supplied by the affected nerve, there may be preservation of conductivity, and voluntary action potentials may be noted, suggesting a good prognosis. Much work has been done trying to find ways to determine early the possible severity of damage in order to properly prognosticate and possibly even initiate curative procedures.<sup>2</sup> Unfortunately, the damage to the nerve may progress after the patient with clinical paralysis is first studied. Intact conductivity, seen in the first week, suggesting early and full recovery, may be lost in the second week. I, therefore, suggest that unless early changes are sought as possible indications for decompression or steroid therapy, it is wise to wait two to three weeks before electrodiagnostic studies are done, at which time a definite prognosis may be made.



If tests are performed earlier, then repeat studies should be done to assure recognition of extension of damage.

**5. Nerve injuries:** In closed nerve injuries, conduction velocity studies and electromyography are extremely helpful, not only for prognostic reasons, but to determine management. If nerve conduction remains present immediately after injury at the area of insult, or below the damaged area after 72 hours, continuity of at least some nerve fibers is present. In these patients a conservative approach will usually give best results. If, however, a complete severance is evident, an exploration is indicated. To further assess recovery, electromyography will show earliest evidence of possible reinnervation.

**6. Lower motor neuron disease:** In generalized lower motor neuron disease, nerve conduction studies will be decisive in implicating the peripheral nerve.

**7. Repetitive stimulation tests:** These are mostly used for confirmation of myasthenia gravis, which can frequently be diagnosed clinically, especially in combination with clinical tensilon test. Myasthenic syndrome, which is observed in a small percentage of patients with bronchogenic carcinoma, however, needs the electrical stimulation test for proper diagnosis. There must be evidence of facilitation after repetitive stimulation or exercise, or both, followed by slowly decreasing amplitude, which is the "sine qua non" of this syndrome.

### **Electromyography**

Clinical electromyography is performed to establish lower motor neuron pathology, differentiate between myogenic and neurogenic disorders, and localize the lesion by carefully observing the distribution of abnormal findings. Some diagnostic problems mostly helped by EMG are:

**1. Unexplained generalized or localized pain, weakness or paresthesias without objective clinical findings or with confusion signs.** Conditions frequently discovered are: carcinomatous neuromuscular disease, early amyotrophic lateral sclerosis (ALS) or disc disease, myositis, and early neuropathy.

**2. Differentiation between ALS and cervical disc disease or spinal cord tumor.** These diseases may all present clinically with upper extremity weakness and atrophy and lower extremity spasticity. Cervical X-rays may be normal, even in a cord or root lesion. The diagnosis of ALS is established by observation of lower motor neuron electromyographic changes in lower extremities when clinically uninvolved except for spasticity.

**3. Differentiation between anterior horn cell disease and peripheral motor neuropathy.** Early ALS or polio may present with just one foot drop, interosseal atrophy or other localized involvement, just as

may motor neuropathy. Motor conduction studies are not always a reliable indicator of peripheral nerve involvement. Sensory nerve conduction studies, which are so helpful in the early diagnosis of the average neuropathy, may be normal if only motor fibers are involved. In such cases, a careful study of the electromyographic pattern will establish the diagnosis and type of abnormality.

**4. Differentiation between muscular dystrophy (limb-girdle or facioscapulohumeral type) and spinal muscular atrophy (Kugelberg-Welander disease).** Clinical findings are so similar in these two diseases that many patients that were considered for many years to be dystrophic were found to have neurogenic muscular atrophy. This is well documented in the literature.<sup>3</sup> Electromyography can easily establish the proper diagnosis since the type of potentials observed in muscular dystrophy are of short duration and normally are of low amplitude, while action potentials typical of spinal muscular atrophy are of increased duration and very high amplitude. The former disease shows good interference pattern on maximal effort, while the latter shows much gapping. Proper diagnosis may be important in genetic counseling and better prognostication.

**5. Differentiation between disc disease and proximal myopathy.** A patient presenting with proximal motor weakness without sensory complaints is usually diagnosed as having some form of myopathy. As disc disease may at times cause only motor involvement and many patients that have cervical arthritis causing root compression may also have lumbosacral degenerative disc disease, a diagnostic problem is evident. Electromyography, again, can easily distinguish between the two.

**6. Differentiation between steroid-myopathy and polymyositis.** Many patients presenting with arthritic symptoms and lab studies suggestive of rheumatoid arthritis are treated intermittently with corticosteroids. After several weeks or months they may present with weakness, and the problem arises of distinguishing between a myopathy secondary to the medication, polymyositis, or neuromuscular involvement secondary to rheumatoid arthritis. Although much experience in electrodiagnosis is necessary to appreciate the small differences in presentation of abnormalities, skillful evaluation is more helpful than any other test, including muscle biopsy.<sup>4</sup>

**7. Differential diagnosis in congenital or early infancy hypotonia.** The "floppy infant" may have benign congenital hypotonia, Werdnig-Hoffmann disease, or congenital myopathy (central core disease, nemaline myopathy, the mitochondrial myopathies and myotubular myopathy). In the absence of a strong family history of neuromuscular disease, electrodiagnostic studies are extremely helpful in establishing a diagnosis.



8. **Anal electromyography.** Electromyographic investigation of the anal sphincter is valuable in establishing the presence of lower motor neuron deficit, and in seeking the cause for enuresis, urinary retention, chronic groin or rectal pain, or chronic bowel problems.<sup>5</sup>

9. **Differentiation between myogenic and neurogenic disorders in ophthalmoplegic conditions.**<sup>6</sup> As ocular muscles are at times the only site of neuromuscular defect, it is helpful to be able to establish the definite site of pathology by observation of electrodiagnostic changes characteristic of myopathy or neurogenic disorders. This, however, is not done routinely in the average clinical EMG laboratory, and it is best accomplished in combined study with an ophthalmologist.

10. **Detection of muscular dystrophy carriers for genetic counseling.** This is another area which is not explored by many clinical electromyographers. Since the judgment of polyphasia (the most difficult aspect of clinical electrodiagnosis) and potential duration decrease is the sole abnormality on which diagnosis is based, minor changes may easily be missed unless harmonic analysis is used. If the electromyograph is equipped with a frequency analyzer, a better quantitative appraisal can be accomplished.<sup>7</sup>

11. **Differentiation between motor system disease, disuse atrophy and hysteria.** An always significant aid in ruling out possible organic disease is the finding of normal electrodiagnostic studies when hysteria is suspected or muscle bulk has been lost by immobilization. This becomes quite important in liability and compensation cases.

12. **Limitations of electrodiagnosis.** Differentiation between various types of degenerative myopathies or neuropathies cannot be made, and it is impossible to distinguish between nerve or root compression of different origin. In patients with marked generalized peripheral neuropathy, concomitant root compression can rarely be ruled out. It is difficult, or often impossible, to diagnose newly developed conditions in the presence of preexisting disease. Thus, the previously laminectomized patient with recurrence of symptoms presents problems in distinguishing between old and new lesions.

Unfortunately, much skill, experience and critical judgment is necessary to properly interpret the observed electrical signals and become proficient in this form of examination. This may be the reason for some of the laxity in acceptance of this procedure in some institutions. As pointed out in the foregoing article, a diagnosis can often be most accurate if an expert neurological examination is supplemented by electrodiagnostic studies. It, furthermore, offers new dimensions in management, prognosis and the study of the many fascinating and still poorly understood phenomena in neurophysiology.

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## **the heart page**

# **Studies of Sudden Death and Myocardial Infarction in Baltimore City**

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Previous studies have shown that sudden deaths attributed to arteriosclerotic heart disease are the leading cause of death in the 40 to 64 age group. Because of the rapidity of these deaths, most occur outside of a hospital and are therefore not preventable by currently available hospital treatment.

Begun in June 1970, a study of sudden death and myocardial infarction is being conducted in Baltimore as a joint effort of The Johns Hopkins School of Public Health, the Office of the Chief Medical Examiner of the State of Maryland, and approximately 11 hospitals in the Baltimore area. All sudden nontraumatic deaths in the 20 to 64 age group in a defined area of Baltimore city with a population of about 520,000 people are ascertained. Sudden deaths are defined as occurring within 24 hours of onset in individuals able to function relatively normally in the community. At the same time, all patients with transmural myocardial infarctions ages 20 to 64 living in the area of the study are identified by reviewing the admissions to the 11 hospitals that supply practically all of the medical care for this area.

*Supported by contract—NIH 70-2071 from the Myocardial Infarction Branch of the National Heart and Lung Institute in Bethesda, Maryland.*

The basic aims of the study are to determine: 1. The possible immediate precipitating factors for sudden deaths and myocardial infarctions, 2. Whether changes in an individual's life style or in the environment may increase the risk of sudden death, 3. The significance of patient delay or physician delay following the development of symptoms as a factor in survival after a heart attack. The importance of prodromal symptoms is of particular interest, 4. To study the correlation between the pathology, pathophysiology, and epidemiological characteristics of sudden death, and 5. To suggest models for the prevention of sudden death.

Deaths are identified from both the reports to the Medical Examiners Office (M.E. death) and by a weekly check of the death certificate files (non M.E. deaths). An investigator from the Medical Examiner's Office interviews the witnesses and the family members as soon as possible after the event. Approximately two to three weeks later the family is



reinterviewed to obtain background data, especially a history of prior medical care, diseases, habits, and various psychosocial and demographic characteristics. Further information is also obtained from physicians who have treated the deceased, and prior hospitalizations are reviewed. Ambulance reports are also studied in order to determine whether the deceased was alive when the ambulance was called and arrived at the hospital. For deaths that are reported to the Medical Examiners Office and autopsied, a detailed examination is done including careful dissection of the coronary arteries and myocardium.

### **Preliminary Study Results**

Preliminary results of the first seven months of the study are now available. Between July 1970 and the end of January 1971, there were 269 deaths definitely attributed to arteriosclerotic heart disease (ASHD) and 182 (67%) were sudden. The percentage of deaths that were sudden was similar in blacks and whites and higher in white men (71%) as compared to white women (57%). Besides the 182 sudden (ASHD) deaths, there have been 102 sudden nontraumatic deaths attributed to other causes including 52 due to fatty livers and alcoholism. In 169 of the 182 (ASHD) sudden deaths, the length of survival could be determined. Fifty-eight (34%) died instantaneously, 33 (20%) within two hours, 58 (30%) were unwitnessed, and only 28 (17%) occurred from 2 to 24 hours. Only 57 (21%) of the 269 ASHD deaths have occurred in a hospital. Most of the ASHD sudden deaths had a prior clinical history of either heart disease, hypertension, or diabetes. Thus, 54% had a prior history of heart disease, 41% hypertension, and 16% diabetes. Only 19% of the ASHD sudden deaths did not have a history of at least one of these diseases.

In the present study, about one third of the sudden death patients had seen a physician within two weeks prior to their death. Twenty-nine of the 56 visits were routine follow-up for cardiovascular disease, 19 for new cardiovascular symptoms, and

eight for symptoms apparently unrelated to cardiovascular disease.

The preliminary findings of the pathology study have shown that practically all of the sudden ASHD deaths have severe coronary atherosclerosis resulting in at least 80% to 100% narrowing in one major vessel and that three or four major coronary arteries (left main, left anterior, descending circumflex, and right) have at least 50% narrowing of the cross-sectional areas of their lumens. The disease appears to be diffuse and involves both the proximal and distal segments of the arteries but apparently rarely involves the small vessels of the heart. Only about 25% of these deaths have a fresh thrombosis, or a major hemorrhage in a plaque. Also in the cases with a fresh thrombosis or hemorrhage in a plaque, a clear history of prodromal symptoms can be ascertained suggesting that the length of survival from onset of the pathological process to death was probably several days.

As previously noted, the high frequency of out of hospital (ASHD) deaths remains the major stumbling block in the reduction of coronary disease mortality in the community. Coronary care units have done much to reduce the in-hospital mortality but can do little to reduce the major mortality outside of the hospital. The severity of the underlying atherosclerosis raises doubts about the value of any procedure short of primary prevention of atherosclerosis to reduce coronary disease mortality. On the other hand, there is little evidence of any acute pathological changes in the coronary arteries and myocardium to account for the sudden death. Possibly the factors that precipitate sudden death are extracardiac in origin and result in sudden death or myocardial infarction in the susceptible individual, ie, the individual with severe underlying coronary atherosclerosis. Without a vigorous approach to primary prevention, identification of precipitating factors, early out of hospital identification, and treatment of potential sudden death victims, the mortality from coronary disease will probably not be reduced in the community.

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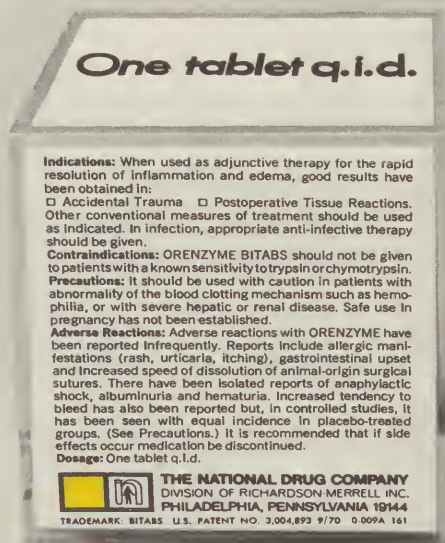
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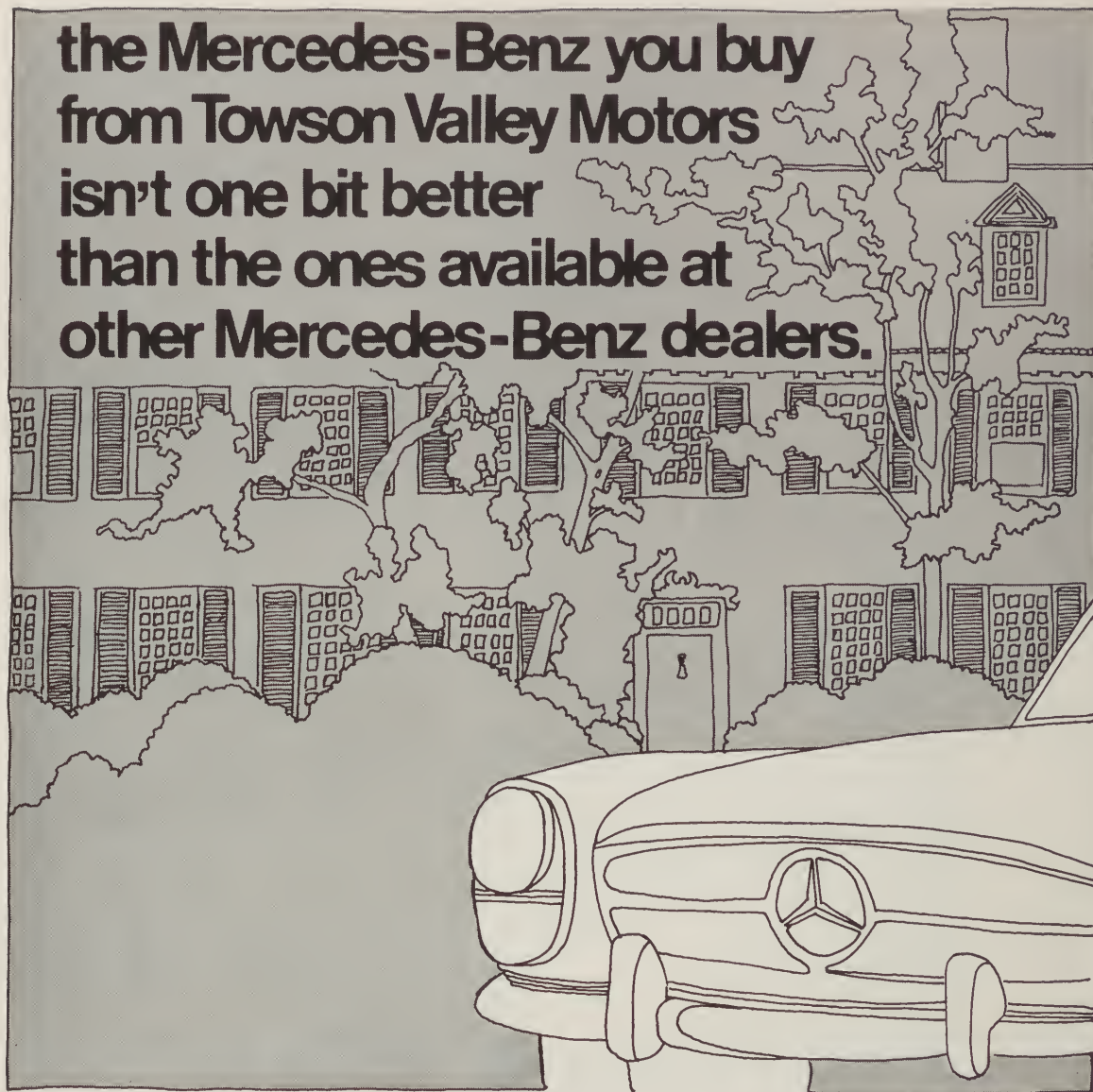
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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other

antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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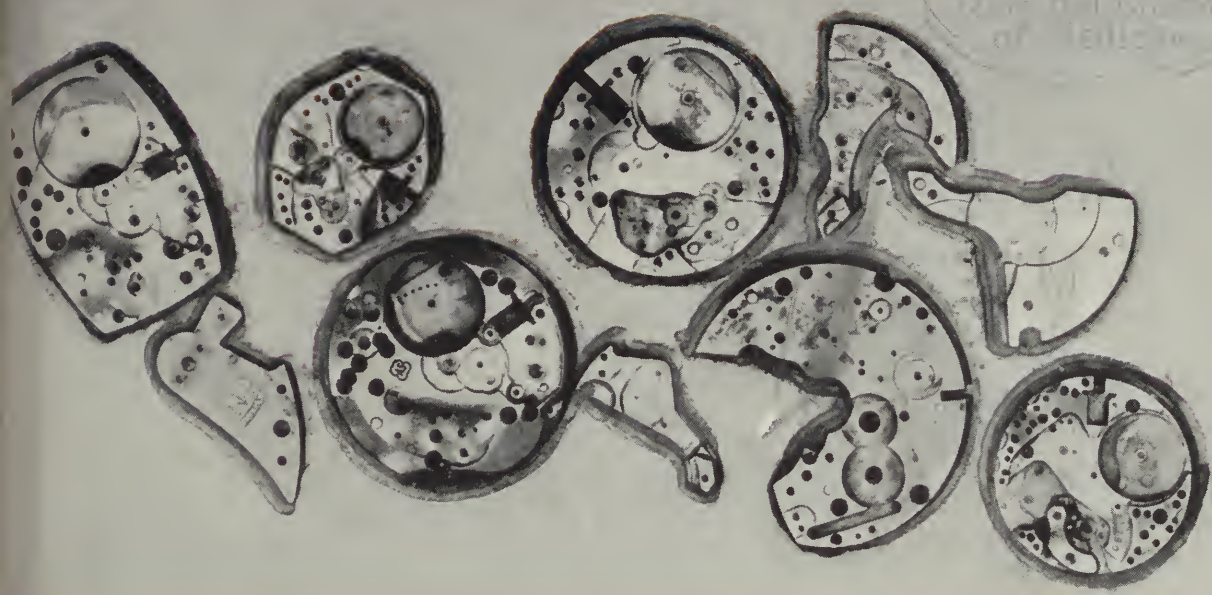
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# Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.<sup>1,2</sup>

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

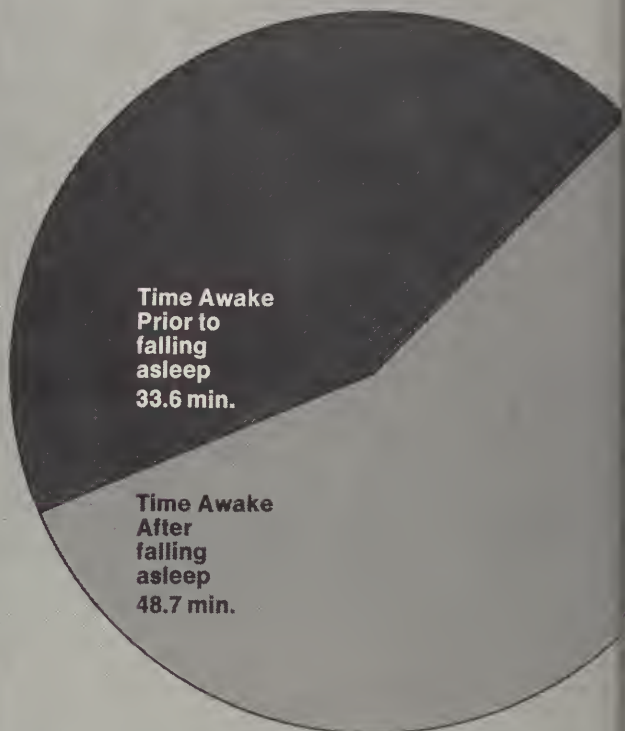
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

**References:** 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

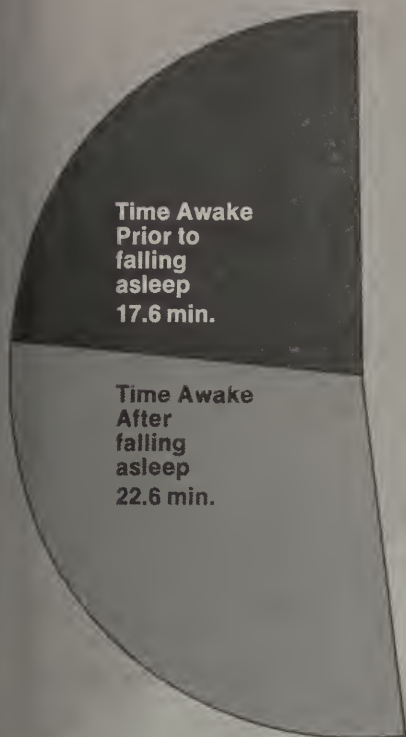
Before  
Dalmane  
(flurazepam HCl)





# Kind slept through the night

On  
Dalmane  
(flurazepam HCl)



Average sleep laboratory measurements in cited studies

Parameter	Before Dalmane	On Dalmane
Time required to fall asleep	33.6 min.	17.6 min.
Wake time after onset of sleep	48.7 min.	22.6 min.
Number of wakeful periods after onset of sleep	12.2	8.4
Total sleep time	420.0 min.	447.5 min.
Total sleep percent	88.6	94.5

**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



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ON THE COVER: This month's cover is entitled "Time" and was created by Edna Galeano, an art major at Towson State College. The print combines sculpture with an intaglio print, using pieces of old watches.



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# Doctors take note...

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**SEPTEMBER 20-24, 1971**

## **AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**

Annual Meeting: Convention Center, Las Vegas, Nevada. For further information, write: C. M. Kos, MD, Executive Secretary Treasurer, American Academy of Ophthalmology and Otolaryngology, 15 Second Street SW, Rochester, Minnesota, 55901.

**SEPTEMBER 20-24, 1971**

## **AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Endocrinology and Metabolism: Duke University Medical Center Amphitheater, Duke University Medical Center, Durham, North Carolina. Credit 32¾ hours allowed toward AMA "Physician's Recognition Award." Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**SEPTEMBER 23-25, 1971**

## **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Meeting—Central Association of Obstetricians and Gynecologists: White Sulphur Springs, West Virginia. Contact: David G. Decker, MD, 200 First St., SW, Rochester, Minn. 55901.

**SEPTEMBER 24-25, 1971**

## **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS/OBSTETRICAL AND GYNECOLOGICAL SOCIETY, NEW YORK MEDICAL COLLEGE**

11th Annual Residents' Day Meeting and Postgraduate Seminar: New York city. Contributors to the field of gynecologic endocrinology and infertility will discuss the diagnostic and therapeutic aspects of infertility and gynecologic endocrine therapy. Write: J. Victor Reyniak, MD, Director, Section of Gynecologic Endocrinology and Sterility, New York Medical College, Flower and Fifth Avenue Hospitals, 1249 Fifth Avenue, New York, New York 10029.

**SEPTEMBER 27-30, 1971**

## **AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS**

Course on Emergency Care: Madison, Wisconsin. Fee: \$50. Write: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611.

**SEPTEMBER 1971**



**OCTOBER 7-8, 1971**

**STERILE DISPOSABLE DEVICE COMMITTEE, HEALTH INDUSTRIES ASSOCIATION**

Technical Symposium—Sterile Disposable Devices: Present and Future: Hotel Sonesta, Washington, D.C. Write: Garis F. Distelhorst, Secretary, Sterile Disposable Device Committee, 1225 Connecticut Ave., NW, Washington, D.C. 20036.

**OCTOBER 7-9, 1971**

**JOHNSON AND JOHNSON**

Emergency Department Nursing Instructional Course: The Commodore Hotel, New York, New York. Conducted by the New York-Brooklyn Regional Committee on Trauma of the American College of Surgeons in conjunction with the Cornell University School of Nursing. For further information, contact: New York-Brooklyn Regional Committee on Trauma of the ASC, P.O. Box 588, Lenox Hill Station, New York, New York, 10020.

**OCTOBER 9, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Fall Seminar of the Shufelt Society—Quality of Life: San Jose, California. Speakers include W. Hugh Missildine, MD, Alan Guttmacher, MD, and Alexander P. Runciman, MD. Contact: Richard D. Sheehan, MD, 15955 Samaritan Dr., San Jose, Calif. 95124.

**OCTOBER 11-13, 1971**

**AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Postgraduate Course—Obstetrics and Gynecology: Denver, Colorado. Topics to be discussed include ultrasound, laparoscopy, cryosurgery, and the use of chemotherapy in gynecological malignancies. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

**OCTOBER 11-15, 1971**

**AMERICAN ASSOCIATION FOR LABORATORY ANIMAL SCIENCE**

22nd Annual Session of the American Association for Laboratory Animal Science: Americana Hotel, New York city. A new program format of morning formal scientific papers, and in the afternoons seminars and workshops, will be introduced. For further information, write: National Headquarters, AALAS, 4 East Clinton Street, P.O. Box 10, Joliet, Illinois 60434.

**OCTOBER 12-14, 1971**

**AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**

Course—Inside the Emergency Department: Miami Beach, Florida. Contact: Eugene C. Nakfoor, MD, Program Chairman, American College of Emergency Physicians, 241 E. Saginaw St., East Lansing, Mich. 48823.

**OCTOBER 13-15, 1971**

**DEPARTMENT OF DERMATOLOGY, NEW YORK UNIVERSITY SCHOOL OF MEDICINE**

Symposium—Allergic Eczematous Contact Sensitization: Alumni Hall, New York University Medical Center, 550 First Ave., New York city. Merrill W. Chase, MD, will speak on "The Mechanism of Contact Allergy and the Concept of Peripheral Sensitization." For further information, write: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N. Y. 10016.

**OCTOBER 14-16, 1971**

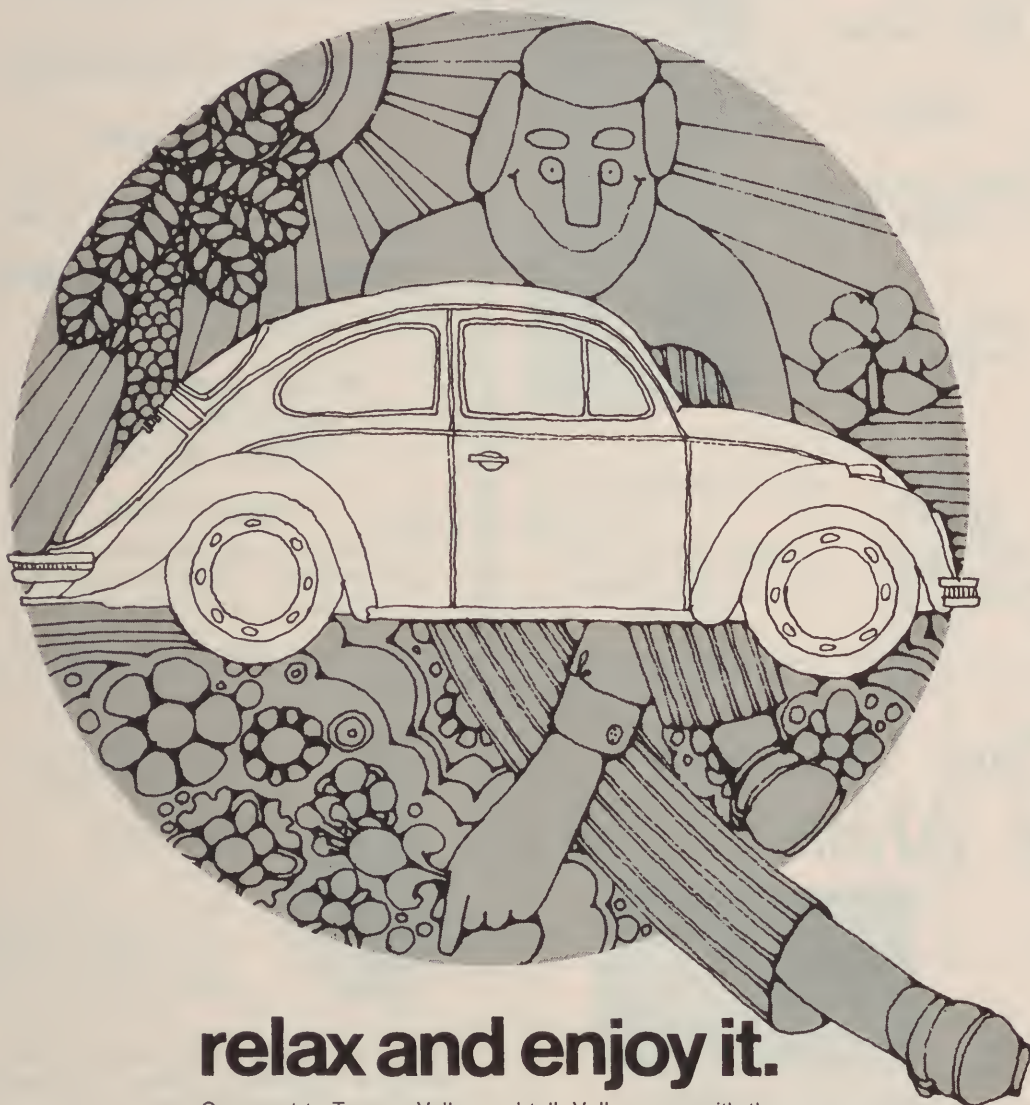
**AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS**

Course on Emergency Care: New York, New York. Fee: \$50. Contact: American Academy of Orthopaedic Surgeons, 430 E. N. Michigan Ave., Chicago, Ill. 60611.

*(Continued on page 12)*



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# executive director's newsletter

September 1971

PHYSICIANS'  
CHARGES  
INCREASE?

THE INTERNIST, the ASIM publication, quoting from a relatively unknown monthly report published by the Office of Research and Statistics, Department of HEW, reveals the following:

TABLE I  
Physicians' Charges

	<u>Total</u>	<u>Surgical</u>	<u>Medical</u>	<u>Number Bills</u> <u>in Millions</u>
Last half 1966	99	198	65	0.9
1967	69	172	51	20.2
1968	66	164	51	25.6
1969	66	163	51	33.5
First half 1970	66	163	50	16.0

TABLE II

<u>General Practice:</u>	<u>1969</u>	<u>1970</u>
Total Av. Chge. per Pt.	116.74	117.39
Av. Off. Med. Svce.	24.61	25.00
Av. Home Med. Svce.	22.92	23.42
Av. Hosp. Med. Svce.	105.60	103.51
<u>General Surgeons:</u>		
Av. Surg. Chge. per Pt.	210.03	202.60
<u>Ophthalmology:</u>		
Av. Surg. Chge. per Pt.	233.62	243.18
<u>Orthopedic Surgery:</u>		
Av. Surg. Chge. per Pt.	240.39	237.47
<u>Urology:</u>		
Av. Surg. Chge. per Pt.	225.39	230.50

TABLE III  
Hospital Charges

	<u>Per Claim</u>	<u>Per Day</u>
7/66-12/67	634	47
1968	744	56
1969	842	64
6 months, 1970	919	72

Note that all physician figures involve charges, not payments made by Medicare nor figures reported from a survey.

DRUG ABUSE  
EMERGENCY  
TREATMENT  
MANUAL

A drug abuse emergency treatment manual is now available. It is published jointly by the state's Drug Abuse Administration and the Faculty. Individual copies of the manual are available through the Faculty



ETHICAL  
RULINGS

office. Copies have been mailed to all hospital Emergency room departments.

Physicians are repeatedly sending out announcements without having them cleared through the Faculty office. This places the physician in an embarrassing position because unapproved announcements constitute not only unethical practices, but illegal acts under the Medical Practice Act.

Regulations of the Board of Medical Examiners and Commission on Medical Discipline require that the "format" of such announcements be approved by the Faculty. Other restrictions governing the size, information concerned, and other data also apply.

PROPER  
TELEPHONE  
MANNERS

When one physician telephones another, it is proper for the secretary or nurse to have the physician calling ready to speak when the physician who has been called answers.

Instances have occurred whereby physicians have been interrupted from their busy practice to wait on the telephone for long periods of time before the calling physician is available to talk with them.

Common courtesy dictates that the physician placing the call be immediately available when the call is completed.

FOURTH  
NATIONAL  
SURVEY

The fourth national survey on the cost and use of medical services and the extent of insurance payment is now underway. The survey is being conducted by the Center for Health Administration and the National Opinion Research Center.

If physicians are approached in this connection, they are urged to cooperate.

NEWLY  
HONORED

Henry P. Laughlin, MD, of Mt. Airy, has been elected President of the American College of Psychoanalysis. The election took place in May 1971.

  
Executive Director



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## Doctors Take Note . . .

*(Continued from page 6)*

**OCTOBER 16, 1971**

### **AMERICAN COLLEGE OF PHYSICIANS**

Tri-State Regional Meeting: University of Maryland Hospital, Baltimore, Maryland. All physicians, house staff, and medical students are invited to attend. Write: Merrill J. Snyder, MD, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201.

**OCTOBER 16-21, 1971**

### **AMERICAN ACADEMY OF PEDIATRICS**

40th Annual Meeting: Palmer House Hotel, Chicago, Ill. The meeting will feature a versatile program of scientific presentations, seminars, and discussions. For further information, write: AAP, 1801 Hinman Avenue, Evanston, Illinois 60204.

**OCTOBER 18-19, 1971**

### **UNITED STATES PHARMACOPEIAL CONVENTION, INC.**

Conference on Bioavailability of Drugs: Auditorium of the National Academy of Sciences, 2101 Constitution Avenue, N.W., Washington, D.C. For further information, call: Mr. Robert H. Henry (301)-881-0666.

**OCTOBER 18-22, 1971**

### **AMERICAN COLLEGE OF SURGEONS**

57th Annual Clinical Congress of the American College of Surgeons: Dennis and the Shelburne Hotels, Atlantic City, New Jersey. The program will include: 17 postgraduate courses; some 46 panels; and approximately 350 scientific and industrial exhibits. For further information, write: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

**OCTOBER 18-22, 1971**

### **AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Rheumatic Diseases: Pathology, Immunology, Diagnosis and Treatment: Francis A. Countway Library Auditorium, Boston, Massachusetts. Write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**OCTOBER 19-22, 1971**

### **AMERICAN COLLEGE OF SURGEONS**

Course—Abdominal and Chest Trauma: Atlantic City, New Jersey. Write: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

**OCTOBER 20-23, 1971**

### **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Fifth Scientific Session and Second West Coast Basic Colposcopy Course on the American Society for Colposcopy and Colpomicroscopy: Los Angeles, California. Contact: Duane E. Townsend, MD, Program Chairman, Women's Hospital, LAC/USC Medical Center, Los Angeles, California 90033.

*(Continued on page 34)*





ARTHUR E. COCCO, MD  
Journal Representative

## Baltimore City Medical Society

# Board Of Directors Meets

The Board of Directors met on July 13 from 4:30 PM to 8:00 PM.

After calling the meeting to order and adopting the minutes of the June 1 meeting, Drs. John Eyring and Rafael Garcia-Bunuel of the Peer Review Committee joined the Board to present the standards established for the use of oxytocics. These standards were discussed and the Board supported the efforts of the Committee in establishing parameters of usual and customary methodology of practice. It was suggested that before final action by the Board, these standards should be submitted for consideration by the Maryland OB-GYN Society. The approved standards will be published for the membership.

Charles Flom, MD, then presented a discussion of a mobile medical unit. Dr. Flom has expended great effort and time in the investigation of the relative costs and values of a mobile medical unit and submitted a very lucid report to the Board. The Board supported and encouraged Dr. Flom's efforts in general and requested that it be kept informed of future developments.

The Chairman of the Public Medical Education and Public Relations Committee, Jack M. Zimmerman, MD, reported that meetings had been held with two television stations, both of which are interested in producing programs in conjunction with the medical society. The Committee agreed to utilize WMAR-TV and produce two panel discussion programs with visual aids prepared by the studio and possibly include audience participation. The subjects of the shows would be availability of emergency care and cost of health care.

Dr. Zimmerman also reported that the Committee is looking into ways of achieving better communica-

tions with the press and has suggested that regular meetings with reporters be established. The suggestion that the committee might work more effectively if it were divided, having one committee for public relations and another for public medical education, was considered feasible by Dr. Zimmerman and was taken under consideration by the president.

A problem encountered by the Professional Relations Committee of having a large number of complaints registered against one physician was presented to the Board by Richard L. London, MD, the chairman of that committee. It was agreed to refer this to the Peer Review Committee for further investigation and disposition.

A proposal that the Society arrange a seminar early in the fall on the plans being made in the city by various groups for the delivery of health care was submitted by the Policy and Planning Committee. The Society is represented on three of these groups and it was felt that the membership should be made aware of new developments. The groups referred to are: the Maryland Consortium for Health Sciences, the First Maryland Health Care Corporation, the Maryland Health Maintenance Committee, Inc., and the North Central Baltimore Health Consortium. The Board accepted this proposal and a committee will be appointed to arrange a seminar.

A letter from John B. De Hoff, MD, MPH, as Acting Commissioner of Health, urged the Society to take affirmative and continuous action to improve patient care in Baltimore nursing homes. Dr. Robert Goldstein reported that there is presently a Nursing Home Liaison Committee working in Med-Chi to establish standards for the position of principal nursing home physicians and to give these physicians



adequate authority to obtain and maintain good quality patient care. In view of this, it was agreed to take no action at this time.

The request of the Environmental Problems Committee that the Society join the Better Air Coalition was approved.

Murray Kappelman, MD, wrote to the Board requesting support for Center Stage. Although the Board felt this an important cultural activity in the city and expressed the hope that individual physicians would offer support, it was agreed that the Society should not deviate from the established policy of not financially supporting fund-raising efforts.

Matthew Tayback, MD, Assistant Secretary of Health and Mental Hygiene, joined the meeting to discuss the contractual arrangements made with the Braxton/Carter Associates. The contact between the health department and the associates defines the types of services to be provided and the manner in which the state will reimburse the physicians. In general, this contract offers a fee considerably higher than the fee paid to physicians for office visits made by Medicaid patients. Dr. Tayback explained that the fee was derived from the budget estimate submitted by Braxton/Carter Associates and compared with charges made by hospitals for outpatient care. Similar agreements are in stages of discussion with The Johns Hopkins Hospital, the Greater Baltimore Medical Center, and the Bon Secours Hospital. This proposal generated lively debate within the Board with numerous questions left unanswered. It was finally proposed that a "Blue Ribbon" Committee of practicing physicians of the Baltimore City Medical Society be established to investigate and publish, if appropriate, a report concerning the pros and cons of such contractual arrangements.

The Board was informed that the Areawide Health Planning Agency of the Regional Planning Council is conducting an evaluation of emergency medical facilities in the Baltimore area. Mr. John L. Green, director of the Areawide Health Planning Agency, explained in a letter that the basic concept of area-wide planning is the mobilization of public health

agencies, private health organizations and institutions, citizen and neighborhood organizations into a medical-governmental-community coalition. Further contacts between this important agency and the City Medical Society will be established.

A letter from William McC. Hiscock, director for the Comprehensive Health Care Planning Agency of the Regional Planning Council, stated that this organization has accepted a planning task directed to studying the feasibility of converting the U.S.P.H.S. Hospital in Baltimore into a community health facility. The request was made by the U.S. Department of Health, Education and Welfare. This matter will be considered further to ensure that the Society is adequately represented.

A report from Marie C. Rigaud, MD, regarding a drug abuse education program entitled Project DAWN was considered by the Board. It was apparent that there is much overlapping of activities in the area of drug abuse between the city and state health departments. It was agreed to send a letter to the Secretary of Health and Mental Hygiene urging that every effort be made to coordinate the plans made for the treatment of drug addicts and in the field of drug abuse education between the city and state health departments. This will provide more adequate, efficient, and effective services in the city.

The Board noted for information a letter from Homero R. Garza of the Southwest Program Development Corporation congratulating John B. De Hoff, MD, MPH, for his part in developing the health consortium in Baltimore.

The Board also noted as information a letter from Bernard B. Perlman, a Baltimore artist, who offered to provide art appreciation courses aimed specifically for physicians. Physicians interested in pursuing this type of program are urged to contact Mr. Bernard Perlman, 6603 Baythorne Rd., Baltimore, 21209.

Philip Wagley, MD, informed the members present that a new committee had been formed for combating Huntington's Chorea and would like to have the names of persons and families in this area afflicted with this disease.

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# Founding of the John Staige Davis Society of Plastic Surgeons of Maryland, Inc.

The John Staige Davis Society of Plastic Surgeons of Maryland was formally founded on March 10, 1971 with the election of its first slate of officers: Robert W. Johnson, III, MD, of Baltimore, President; John C. Clark, MD, of Hagerstown, Vice-President; and Stanley Klatsky, MD, of Baltimore, Secretary-Treasurer. The charter members of the new society are: Elliott M. Berg, MD, John C. Clark, MD, Raymond M. Curtis, MD, W. Bowdoin Davis, MD, Frederik C. Hansen, Jr., MD, John E. Hoopes, MD, Michael E. Jabaley, MD, Arthur R. Jasion, MD, Robert W. Johnson, III, MD, Bernard Kapiloff, MD, Edward J. Kitlowski, Jr., MD, Stanley A. Klatsky, MD, Octavius P. Large, MD, Lawrence D. Pinkner, MD, Jerome S. Plasse, MD, Mario Vahos, MD, and Hans R. Wilhelmsen, MD. Edward A. Kitlowski, MD, was made a member of the society.

John Staige Davis, MD, probably was the first physician in this country to devote his entire practice to plastic surgery. He published the first American text on plastic surgery in 1919, a book profusely illustrated by photographs of his own cases and drawings made by his wife, Kathleen Gordon Bowdoin.

"Staige Davis", as he was called, was born in Norfolk, Virginia, January 15, 1872, the son of an Army surgeon. Much of his youth was spent traveling. There was no school available when his parents moved to the Dakota territories near an Indian agency and his parents were his only teachers. He later went to Episcopal High School in Alexandria, Virginia, and Saint Paul's School in Garden City, Long Island. He attended and graduated from the Yale University in 1895 and The Johns Hopkins Medical School in the class of 1899. After 1899, he remained in Baltimore to practice surgery. He expressed the desire to write a book on plastic surgery while working under Dr. Halsted; however, Dr. Halsted was not interested. Staige Davis began publishing papers on reconstructive surgery as early as 1907. His book, *Plastic Surgery*, was published in 1919, and copies were given to each of the Hopkins "Big Four", Doctors Halsted, Welch, Kelly, and Osler. He never received a word from Dr.

Halsted acknowledging the book. He continued to produce numerous papers on skin grafting and the use of the z-plasty until his death on December 23, 1946, at the age of 74.

Thus, he was somewhat of a prophet in this country in that his own medical school, The Johns Hopkins Hospital, for many years offered no support commensurate with the unique place of Dr. Davis in this special field of surgery. As a result, the training of plastic surgeons at The Hopkins was delayed and undeveloped in comparison with that of other schools which early recognized the need for such training. John Staige Davis remained as Associate Professor of Surgery at Hopkins until his death in 1946.

He was a member of numerous medical societies. He was one of the founders and the first Chairman of the American Board of Plastic Surgery, which was founded in 1937. He was also a founder-member of the American College of Surgeons and was elected to the Board of Regents just before his death. He had served during the First World War as a captain in the medical corps of the United States Army and was a member of the committee appointed by the Surgeon General to organize plastic surgery units for the Army Medical Corps.

A personal glimpse into the character of the man and his ability might be gained from an excerpt of an article in *The Sunpapers* written at his death by the mother of one of his patients: "He was a gifted man, a brilliant organizer, with capable surgeon's hands, a marvelous vision, and a humane soul; of all these gifts he gave freely to soldiers of two wars and to civilians of every age, race, religion, and creed. Such a man as Dr. John Staige Davis deserves a monument—not one of hard stone—but rather something of a tender nature in keeping with his personality.

Plastic surgery owes a great debt of gratitude to Dr. John Staige Davis; the influence of his life and ideals is still felt. We are proud to dedicate our new society to this great surgeon.

Arthur R. Jasion, MD  
W. Bowdoin Davis, MD  
Baltimore



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**NOTE:** Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Should not be given to patients who have received an MAOI within two weeks.

**Contraindications:** Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

**Warnings:** May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

**Precautions:** When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

**Adverse Reactions:** *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction. **How Supplied:** Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

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**September 24, 1971 12:30 PM**

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Associate Professor of Medicine  
Johns Hopkins University School of Medicine  
Director, Connective Tissue Division  
Department of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, Sept. 27, 1971 12:30 PM  
Wednesday, Sept. 29, 1971 9:00 AM  
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**October 1, 1971 12:30 PM**

### **THE MANAGEMENT OF CARDIAC ARRHYTHMIA**

**Ross Fletcher, MD**  
Chief of Cardiology  
Georgetown University Section  
D.C. General Hospital  
Director of Coronary Care Unit  
D.C. General Hospital

**Sponsor: Sacred Heart Hospital**

Replays: Monday, October 4, 1971 12:30 PM  
Wednesday, October 6, 1971 9:00 AM  
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**October 8, 1971 12:30 PM**

### **CLINICAL PROBLEMS IN THE MANAGEMENT OF STROKE**

**Arthur P. Siebens, MD**  
Professor of Rehabilitation Medicine  
Professor of Rehabilitation Surgery  
Johns Hopkins University School of Medicine  
Rehabilitation Physician-In-Chief  
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, October 11, 1971 12:30 PM  
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**October 15, 1971 12:30 PM**

### **PETECHIAE — CAUSES AND MANAGEMENT**

**William Doyle Calley, MD**  
Assistant Chief of Pediatrics  
Consultant in Pediatric Hematology  
Baltimore City Hospitals  
Assistant Professor of Pediatrics  
Johns Hopkins University School of Medicine

**Sponsor: Baltimore City Hospitals**

Replays: Monday, October 18, 1971 12:30 PM  
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**October 22, 1971 12:30 PM**

### **HYPERLIPIDEMIA**

**Simeon Margolis, MD**  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, October 25, 1971 12:30 PM  
Wednesday, October 27, 1971 9:00 AM  
2:00 PM

**October 29, 1971 12:30 PM**

### **MANAGEMENT OF ADULT ONSET DIABETES**

**Thaddeus E. Prout, MD**  
Chief of Medicine  
Greater Baltimore Medical Center  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Baltimore County General Hospital**

Replays: Monday, Nov. 1, 1971 12:30 PM  
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**November 5, 1971 12:30 PM**

### **THE CHEST FILM AS A MIRROR OF PULMONARY PHYSIOLOGY**

**Theodore Keats, MD**  
Chairman and Professor of Diagnostic Radiology  
University of Virginia School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, Nov. 8, 1971 12:30 PM  
Wednesday, Nov. 10, 1971 9:00 AM  
2:00 PM

**November 12, 1971 12:30 PM**

### **CLINICAL PROBLEMS IN THE MANAGEMENT OF SPINAL CORD INJURY**

**Arthur P. Siebens, MD**  
Professor of Rehabilitation Medicine  
Professor of Rehabilitation Surgery  
Johns Hopkins University School of Medicine  
Rehabilitation Physician-In-Chief  
Good Samaritan Hospital

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Replays: Monday, Nov. 15, 1971 12:30 PM  
Wednesday, Nov. 17, 1971 9:00 AM  
2:00 PM

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November 19, 1971 12:30 PM

### **ISONIAZIDE PROPHYLAXIS FOR TUBERCULOSIS**

**Edmund G. Beacham, MD**  
Chief Chronic Medical Care  
Baltimore City Hospitals  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**Allan S. Moodie, MD, MB, DPH**  
Director, Bureau of Communicable Diseases  
Baltimore City Health Department

**Sponsor: Baltimore City Hospitals**

Replays: Monday, Nov. 22, 1971 12:30 PM  
Wednesday, Nov. 24, 1971 9:00 AM  
2:00 PM

November 26, 1971 12:30 PM

### **TECHNIQUES OF MANAGEMENT IN DIABETES**

**Dean H. Lockwood, MD**  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, Nov. 29, 1971 12:30 PM  
Wednesday, Dec. 1, 1971 9:00 AM  
2:00 PM

December 3, 1971 12:30 PM

### **PITFALLS IN THE INTERPRETATION OF LABORATORY RESULTS**

**Rex B. Conn, MD**  
Professor of Laboratory Medicine  
Director, Department of Laboratory Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, Dec. 6, 1971 12:30 PM  
Wednesday, Dec. 8, 1971 9:00 AM  
2:00 PM

December 10, 1971 12:30 PM

### **CLINICAL PROBLEMS IN CHRONIC RESPIRATORY DISEASE**

**Peter C. Luchsinger, MD**  
Chief, Respiratory Disease Section  
Good Samaritan Hospital  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Good Samaritan Hospital**

Replays: Monday, Dec. 13, 1971 12:30 PM  
Wednesday, Dec. 15, 1971 9:00 AM  
2:00 PM

December 17, 1971 12:30 PM

### **ALDOSTERONE**

**R. Patterson Russell, MD**  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Turner Bledsoe, MD**  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**C. Robert Cooke, MD**  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Good Samaritan Hospital**

No replay for this program

January 7, 1972 12:30 PM

### **HYDROCEPHALUS**

**R. M. N. Crosby, MD**  
Associate Professor of Pediatric Neurology  
University of Maryland School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, Jan. 10, 1972 12:30 PM  
Wednesday, Jan. 12, 1972 9:00 AM  
2:00 PM

January 14, 1972 12:30 PM

### **CLINICAL PROBLEMS IN THE MANAGEMENT OF ASTHMA**

**Philip S. Norman, MD**  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine  
Chief of the Allergy and Hypersensitivity Section  
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, Jan. 17, 1972 12:30 PM  
Wednesday, Jan. 19, 1972 9:00 AM  
2:00 PM

January 21, 1972 12:30 PM

### **PHYSIOLOGIC AND PSYCHOLOGIC RECOVERY FOLLOWING ACUTE ALCOHOL INTOXICATION**

**Richard P. Allen, PhD**  
Director, Psychological Services  
Baltimore City Hospitals

**Robert F. Ward, MD**  
Associate Chief of Psychiatry  
Baltimore City Hospitals

**Sponsor: Baltimore City Hospitals**

Replays: Monday, Jan. 24, 1972 12:30 PM  
Wednesday, Jan. 26, 1972 9:00 AM  
2:00 PM

January 28, 1972 12:30 PM

### **CLINICAL USES OF NEWER ANTIBIOTICS**

**Patricia Charache, MD**  
Assistant Professor of Medicine  
Assistant Professor of Microbiology  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, Jan. 31, 1972 12:30 PM  
Wednesday, Feb. 2, 1972 9:00 AM  
2:00 PM

February 4, 1972 12:30 PM

### **THE DIAGNOSIS OF COAGULATION DISORDERS**

**Earl W. Campbell, MD**  
Consultant in Hematology  
National Cancer Institute  
National Institute of Health

**Sponsor: Sacred Heart Hospital**

Replays: Monday, Feb. 7, 1972 12:30 PM  
Wednesday, Feb. 9, 1972 9:00 AM  
2:00 PM

February 11, 1972 12:30 PM

### **CLINICAL PROBLEMS IN ARTHRITIS**

**Mary Betty Stevens, MD**  
Associate Professor of Medicine  
Physician-In-Charge, Arthritis Clinic  
Associate Physician-In-Charge, Connective Tissue Clinic  
Associate Physician-In-Charge, Polyarthritis Clinic  
Johns Hopkins University School of Medicine  
Chief of Connective Tissue Division  
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, Feb. 14, 1972 12:30 PM  
Wednesday, Feb. 16, 1972 9:00 AM  
2:00 PM

February 18, 1972 12:30 PM

### **THE CORONARY CARE UNIT AND THE COMMUNITY**

**Gustav C. Voigt, MD**  
Chief, Cardiovascular Division  
Baltimore City Hospitals  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Baltimore City Hospitals**

Replays: Monday, Feb. 21, 1972 12:30 PM  
Wednesday, Feb. 23, 1972 9:00 AM  
2:00 PM



**February 25, 1972 12:30 PM**

### **CONTRACEPTION**

**J. Courtland Robinson, MD**

Associate Chief of Obstetrics and Gynecology  
Baltimore City Hospitals

**D. Frank Kaltreider, MD**

Chief of Obstetrics and Gynecology  
Baltimore City Hospitals

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, February 28, 1972 12:30 PM  
Wednesday, March 1, 1972 9:00 AM  
2:00 PM

**March 3, 1972 12:30 PM**

### **THE THERAPY OF COAGULATION DISORDERS**

**Earl W. Campbell, MD**

Consultant in Hematology  
National Cancer Institute  
National Institute of Health

**Sponsor: Sacred Heart Hospital**

Replays: Monday, March 6, 1972 12:30 PM  
Wednesday, March 8, 1972 9:00 AM  
2:00 PM

**March 10, 1972 12:30 PM**

### **CLINICAL PROBLEMS IN CONNECTIVE TISSUE DISEASE**

**Mary Betty Stevens, MD**

Associate Professor of Medicine  
Physician-In-Charge, Arthritis Clinic  
Associate Physician-In-Charge, Connective Tissue Clinic  
Associate Physician-In-Charge, Polyarthritis Clinic  
Johns Hopkins University School of Medicine  
Chief of Connective Tissue Division  
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, March 13, 1972 12:30 PM  
Wednesday, March 15, 1972 9:00 AM  
2:00 PM

**March 17, 1972 12:30 PM**

### **FIVE-YEAR EXPERIENCE OF CORONARY CARE UNIT—BALTIMORE CITY HOSPITALS**

**Gustav C. Voigt, MD**

Chief, Cardiovascular Division  
Baltimore City Hospitals  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Baltimore City Hospitals**

Replays: Monday, March 20, 1972 12:30 PM  
Wednesday, March 22, 1972 9:00 AM  
2:00 PM

**March 24, 1972 12:30 PM**

### **HOST DEFENSE MECHANISMS**

**Dexter Seto, MD**

Assistant Professor of Pediatrics  
Assistant Professor of Microbiology  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, March 27, 1972 12:30 PM  
Wednesday, March 29, 1972 9:00 AM  
2:00 PM

**March 31, 1972 12:30 PM**

### **GASTROINTESTINAL BLEEDING**

**Vernon M. Smith, MD, FACP**

Professor of Clinical Medicine  
University of Maryland School of Medicine  
Chief of Gastroenterology  
Mercy Hospital

**Sponsor: Mercy Hospital**

Replays: Monday, April 3, 1972 12:30 PM  
Wednesday, April 5, 1972 9:00 AM  
2:00 PM

**April 7, 1972 12:30 PM**

### **PRACTICAL ASPECTS OF THE PRACTICE OF NEUROLOGY**

**Barbara Hulfish, MD**

Assistant Professor of Neurology in Psychiatry  
University of Maryland School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, April 10, 1972 12:30 PM  
Wednesday, April 12, 1972 9:00 AM  
2:00 PM

**April 14, 1972 12:30 PM**

### **CLINICAL MANAGEMENT—USE OF THE PHYSICIAN'S ASSOCIATE**

**John Collins Harvey, MD**

Professor of Medicine  
Johns Hopkins University School of Medicine  
Executive Vice-President and Medical Director  
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, April 17, 1972 12:30 PM  
Wednesday, April 19, 1972 9:00 AM  
2:00 PM

**April 21, 1972 12:30 PM**

### **PHYSIOLOGIC ASPECTS OF AGING**

**Nathan Shock, PhD**

Director, Gerontology Research Center, N.I.C.H.D.  
Baltimore City Hospitals

**Reubin Andres, MD**

Gerontology Research Center, N.I.C.H.D.  
Baltimore City Hospitals

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Replays: Monday, April 24, 1972 12:30 PM  
Wednesday, April 26, 1972 9:00 AM  
2:00 PM

**April 28, 1972 12:30 PM**

### **GENETIC COUNSELING**

**Peter S. Harper, MD**

Division of Medical Genetics  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, May 1, 1972 12:30 PM  
Wednesday, May 3, 1972 9:00 AM  
2:00 PM

**May 5, 1972 12:30 PM**

### **DIFFERENTIAL DIAGNOSIS OF VERTIGO**

**Francis I. Catlin, MD, ScD**

Associate Professor of Laryngology and Otology  
Associate Professor of Public Health Administration  
Johns Hopkins University School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, May 8, 1972 12:30 PM  
Wednesday, May 10, 1972 9:00 AM  
2:00 PM

**May 19, 1972 12:30 PM**

### **CLINICAL ASPECTS OF AGING**

**Nathan Shock, PhD**

Director, Gerontology Research Center, N.I.C.H.D.  
Baltimore City Hospitals

**Reubin Andres, MD**

Assistant Chief of Clinical Physiology  
Gerontology Research Center, N.I.C.H.D.  
Baltimore City Hospitals

**Sponsor: Baltimore City Hospitals**

Replays: Monday, May 22, 1972 12:30 PM  
Wednesday, May 24, 1972 9:00 AM  
2:00 PM

**May 26, 1972 12:30 PM**

### **FUNCTIONAL UTERINE BLEEDING**

**Georgeanna Seegar Jones, MD**

Associate Professor of Obstetrics and Gynecology  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Wednesday, May 31, 1972 9:00 AM  
2:00 PM



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## CONTINUING PROGRAMS

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(Heard at participating hospitals only)

**SATURDAY MORNINGS — 11:30 AM**

**CONJOINT CLINIC**

Johns Hopkins University  
(September-May)

**TUESDAY MORNINGS — 11:30 AM**

**MEDICAL GRAND ROUNDS**

University of Maryland Hospital  
(September-May)

**WEDNESDAYS — 12 NOON**

**C. P. C.**

The Johns Hopkins Hospital  
(September-May)

**SATURDAY MORNINGS — 10:00 AM**

**MEDICAL GRAND ROUNDS**

The Johns Hopkins Hospital  
(September-May)

**SATURDAY MORNINGS — 8:00 AM**

**PEDIATRIC GRAND ROUNDS**

The Johns Hopkins Hospital  
(All Year)

**Participating hospitals:**

Anne Arundel General, Annapolis  
Baltimore City, Baltimore  
Baltimore County General, Randallstown  
Bon Secours, Baltimore  
Calvert County, Prince Frederick  
Carroll County General, Westminster  
Church Home, Baltimore  
Cumberland Memorial, Cumberland  
Easton Memorial, Easton  
Edward McCready, Crisfield  
Eugene Leland Memorial, Riverdale  
Frederick Memorial, Frederick  
Good Samaritan, Baltimore  
Greater Baltimore Medical Center, Towson  
Harford Memorial, Havre de Grace  
The Johns Hopkins, Baltimore  
Kent & Queen Anne's, Chestertown  
Keswick, Baltimore

Lutheran, Baltimore  
Malcolm Grow Medical Center, Andrews Air Force Base  
Maryland General, Baltimore  
Mercy, Baltimore  
Montgomery General, Olney  
North Charles General, Baltimore  
Peninsula General, Salisbury  
Physicians Memorial, LaPlata  
Provident, Baltimore  
Sacred Heart, Cumberland  
St. Agnes, Baltimore  
St. Joseph, Baltimore  
St. Mary's, Leonardtown  
Sinai, Baltimore  
University of Maryland, Baltimore  
Union Hospital of Cecil County, Elkton  
Union Memorial, Baltimore  
Washington County, Hagerstown

**Other locations:**

Baltimore County Health Dept., Towson  
Civil Defense Headquarters, Baltimore  
Hospital Association of Maryland, Inc., Baltimore  
Medical and Chirurgical Faculty, Baltimore  
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The American Medical Association supported President Nixon's legislation to create a special White House office to coordinate the federal government's fight against drug abuse "as an important element of the national campaign."

The AMA support was outlined by Maurice H. Seevers, MD, chairman of the Department of Pharmacology at the University of Michigan and a member of the AMA Committee on Alcoholism and Drug Dependence, before the House Public Health and Environment Subcommittee. He was accompanied by Richard E. Palmer, MD, a member of the AMA Board of Trustees.

Dr. Seevers said that "under Dr. Jerome Jaffe's able direction the (White House) Special Action Office can become a most effective instrument" in achieving the purpose of the legislation:

"... to focus the comprehensive resources of the federal government and bring them to bear on drug addiction and drug abuse with the immediate objective of promptly and significantly reducing the incidence of drug addiction and drug abuse in the nation within the shortest possible period of time."

"We have two additional observations regarding this stated objective," Dr. Seevers said. First, although prompt and decisive action is to be desired as a goal, it should be clearly recognized that there are no panaceas for the prevention or successful treatment of drug dependence. Drug dependence is a complex phenomenon that does not lend itself to quick or simplistic solutions.

"Our second observation is related to that fact: Well-conceived multifaceted research is needed on a broad scale to devise effective means of coping with this problem.

"With respect to the drugs

themselves, while much is known about their properties, relatively little is known about their precise mode of action in the human organism and the exact nature of the long-term effects of their regular use by man.

"While some of the factors which lead individuals to abuse drugs are understood, science is not yet able to predict who may be vulnerable to drug dependence. The role of drug abuse within the context of a total life style also needs to be more clearly delineated.

"Much work remains to be done in developing new, and evaluating existing treatment methods in terms of the therapeutic needs and psychosocial makeup of the individual patient. Physicians can treat the acute effects of drug abuse and drug dependence, often preventing serious physical and psychological consequences; but medical and sociological management techniques have not been developed so as to insure that a significant number of patients will not return to abuse of drugs and to their patterns of dependence after the acute symptoms have been abated through treatment.

"Methods of 'reaching out' to the young drug abuser must be tested to ascertain the most effective courses that educators, physicians, and those in other professions can pursue.

"Finally, a great deal more work should be carried out with human subjects. Especially needed are longitudinal studies encompassing etiology, diagnosis, treatment and after-care, even

though such studies would require an extended period of years."

Dr. Seevers cautioned that "the technique of treating heroin dependence through methadone maintenance, although offering hope and the possibility of social rehabilitation to a number of dependent persons, is but one of several modalities which can be useful".

\* \* \*

The American Medical Association set forth its recent record on legislation—a record that shows statements in support of health care proposals in 31 of 35 appearances in the 91st Congress and support in the present Congress for medical school expansion, increased financial aid to medical students, family practice training programs, and full funding for maternal and child care programs.

"It requires a certain strain on the process on human logic to interpret this record as negative," the AMA stated.

The AMA's record on legislation was submitted as part of a 39-page statement filed by the organization with the Subcommittee on Administrative Practice and Procedure of the Senate Judiciary Committee. Subcommittee Chairman Sen. Edward M. Kennedy (D.-Mass.) had charged the AMA with maintaining a negative and obstructionist attitude toward proposals to improve health care in the United States during a hearing by the subcommittee on July 14.

Bills supported by the AMA in the 91st Congress included

## THE MONTH IN WASHINGTON



appropriations for hospital and medical facilities construction, appropriations for medical education, drug abuse education and narcotic addict rehabilitation, vaccination assistance programs, and regional medical programs.

The AMA opposed as unnecessary the proposed Commission on Marihuana; opposed one version of the Occupational Safety and Health Act of 1969 but supported another version in both the Senate and House; and opposed certain parts of the Social Security Amendments of 1970 while supporting other parts of the bill.

This affirmative legislative stance has been maintained in the present Congress, as many members of the Senate and House from both sides of the aisle will attest, the AMA noted.

The AMA, in its statement, pointed out that it has introduced its own proposal for financing health care—Medicredit—which would provide government subsidized health insurance to the poor and insure against catastrophic medical costs.

"Medicredit is designed to end for all Americans the burden of expense, and to make all Americans truly equal in their access to all types of medical care," the AMA said.

The organization warned against the "panacea" approach of a massive government health program as recommended by Kennedy.

"We have learned that lesson in welfare and poverty," the AMA said. "Must we learn it anew with health care?"

Regarding specific charges leveled generally by Kennedy against the organization and physicians, the AMA statement termed them "out of date, out of context, and out of balance."

"And his conclusion, that doctors act primarily for gain, is outrageous," the AMA report stated.

Contrary to Kennedy's charges, the AMA noted, it does not and has not opposed vaccination programs, group practice, an increase in the number of physicians, private health insurance, government support for medical education, innovations in medical school curricula, equal opportunity in medical education, or peer review.

The AMA cited its public record and policy statements over the years to refute these charges in detail.

The AMA did object to Medicare at the time of its passage because it believed available government funds should not be used to provide assistance to those who did not need it and because of the unsound actuarial basis on which it was predicated. Premiums have since had to be raised several times to support the program, the AMA noted.

After Medicare became law, both the AMA and physicians generally gave it full support

and worked to make the program a success, the statement added.

In further response to other testimony before the subcommittee on the same date, the AMA denied that it was responsible for "major weakening" of the proposals offered in 1964 by the Heart Disease, Cancer and Stroke Commission, which called for 60 regional clinical and care complexes.

Citing the record once again, the AMA pointed out that the legislation was hastily drawn and was submitted to Congress without sufficient supporting data. This fact was recognized and alluded to by Kennedy himself at the time, the AMA noted.

Two of the commission's own subcommittees had serious reservations about the legislation, the AMA stated, and it was only after AMA officials worked in close cooperation with Johnson Administration officials that the bill was salvaged with an emphasis on pilot projects to test the theories and concepts advanced by the commission.

The AMA completed its statement:

"Let us set aside old, worn-out charges. Let us set aside emotional language and political opportunism. Let us, instead, seek together valid and workable solutions to the health care problems that confront us.

"The AMA will support every such effort."

\* \* \*

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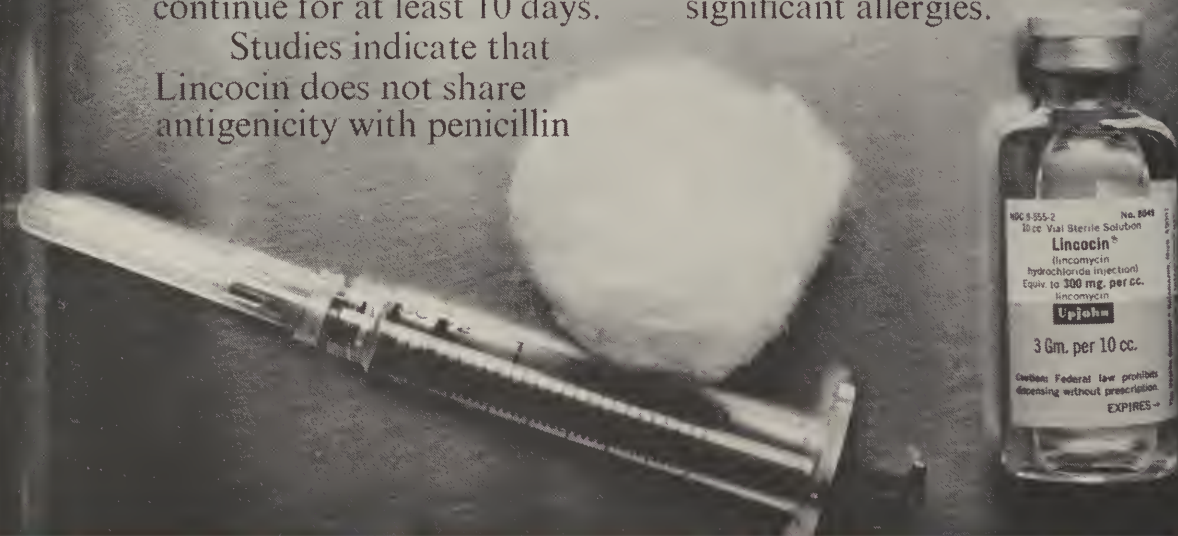


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compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.





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Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with

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**WARNINGS:** Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or

significant allergies. Overgrowth of non-susceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.

**Cardiovascular**—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V. dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. **Local reactions**—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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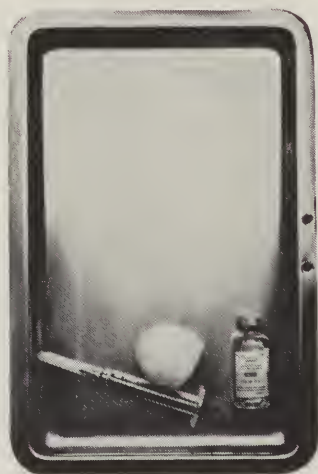
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**Mrs. Elizabeth Patterson**, former Director of Social Services at Clifton T. Perkins State Hospital, has been appointed Chief of Social Works Programs for the Department of Mental Hygiene.

Filling the position vacated by the death of Else T. Jockel, MD, last July, Mrs. Patterson will direct promotion, planning, and development of social service programs in all state hospitals, such as the continuing education program at Crownsville State Hospital.

She will also coordinate the monthly meetings of the chief supervisors of social services at state hospitals and institutions for the mentally retarded.

Current plans for her office include developing a team approach to all services in mental hospitals, coordinating the work of the social services worker with psychiatrists, psychologists, and other hospital staff members.

\* \* \*

**Richard E. Hoover, MD**, chief of ophthalmology at the Greater Baltimore Medical Center, received one of the 1970 Migel Medals of the American Foundation for the Blind for his part in developing the long-cane travel technique.

\* \* \*

**Benjamin F. Trump, MD**, has been appointed the new Chairman of the University of Maryland School of Medicine's Pathology Department. Dr. Trump comes to Maryland from Duke University Medical Center, where he was on the pathology staff since 1965 and was full professor from 1967 until recently. With his appointment, the department is being reorganized to combine clinical pathology with what has been called "anatomic pathology."

\* \* \*

**Robert W. Gibson, MD**, Sheppard-Pratt Hospital's Medical Director, was elected President of the National Association

## MEDICAL NEWS

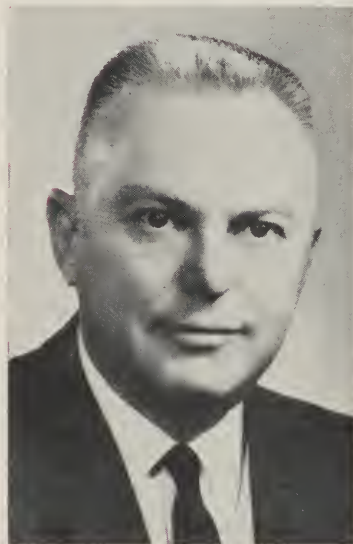
of Private Psychiatric Hospitals at the 40th annual meeting in Key Biscayne, Florida, of the Association's 130 member hospitals. Dr. Gibson had previously served as Vice-President and Secretary of the Association, which is a leader in the development of innovative programs and improvement of quality care in psychiatric hospitals. For the past six years he has been Chairman of its Legislative Committee and has, on numerous occasions, testified before Congressional committees on legislation regarding Medicare and Medicaid programs.

\* \* \*

**Frank J. Ayd, Jr., MD**, internationally known lecturer, writer, and psychiatrist, received an honorary Doctor of Laws degree from the College of Saint Elizabeth during commencement exercises this spring.

Dr. Ayd received his medical degree from the University of Maryland School of Medicine in 1945. The American Board of Psychiatry and Neurology, Inc. certified him as a Diplomate in Psychiatry in 1951. He has lectured in Europe, Asia, Africa, the Orient, Australia, New Zealand, and North America, and is a member of numerous national medical societies. He is a Fellow of the American Psychiatric Association, the American Academy of Psychosomatic Medicine, the American Geriatrics Society, a Fellow and founder of the American College of Neuropsychopharmacology. He is a member of the Royal Medico-Psychological Association (England), and is Vice-Chairman of the Human Life Foundation.

Dr. Ayd has published over 200 scientific articles. He is a contributor to over 30 books. He is editor and publisher of *The Medical-Moral Newsletter* and the *International Drug Therapy Newsletter*. Dr. Ayd is on the editorial staff of several medical journals, and is a member of the National Association of Science Writers, Inc.



**Dr. Ayd**

\* \* \*

**John Brennan, MD**, Senior Research Assistant, has been appointed a member of the Scientific Affairs Committee of the Maryland Psychological Association. This committee has the responsibility for developing the programs of the annual meeting of the Association, and to develop techniques for encouraging the development of the scientific aspects of psychology.

\* \* \*

Three faculty members of the University of Maryland School of Medicine were recently elected officers of the Balti-



more Association of Consulting Psychologists.

**Lawrence Donner, MD**, assistant professor, was elected president. Dr. Donner is a member of the American Psychological Association, and the Maryland Psychological Association.

**James Olsson, MD**, clinical assistant professor, was elected corresponding secretary-treasurer, and **Judith Armstrong, MD**, instructor, was elected recording secretary.

The purpose of the organization is to further professional, civic, and scientific interests of psychologists in Baltimore, as well as to advance psychology as a profession and as a means of promoting human welfare.

\* \* \*

**James G. Zimmerly, MD, JD, MPH**, Fellow, American College of Legal Medicine, recently returned from the Seventh International Medical Legal Seminar in Stockholm, Sweden; Oslo, Norway; and Copenhagen, Denmark. Dr. Zimmerly presented papers on *The Epidemiology of Narcotism in the United States* and on *Drug Abuse Trends and Changing Legal Aspects of Drug Abuse in the United States*.

Dr. Zimmerly is an active member of the Howard County Medical Society.

\* \* \*

The following were recently certified as Diplomates of the American Board of Anesthesiology: **John K. Hairabet, MD**, from Laurel; **Charles J. Kopriva, MD**, from Rockville; **Uaurence J. Krenis, MD**, from Silver Spring; **Alfredo Legaspi, MD**, of Baltimore; **Hector C. Mendez, MD**, of Timonium; and **Alison B. Wilhelm, MD**, of Cheverly.

\* \* \*

**Theodore M. King, MD**, of the Albany Medical College, Albany, New York, has been appointed professor and director of the department of gynecology and obstetrics at The Johns Hopkins University School of Medicine and gynecologist-obstetrician-in-chief of The Johns Hopkins Hospital.

Dr. King, who is now professor and chairman of gynecology and obstetrics at Albany, succeeds **Alan Barnes, MD**, who became vice-president of the Rockefeller Foundation in August 1970. Dr. King will assume his new position in October, 1971.



Dr. King

\* \* \*

Four faculty members of the University of Maryland School of Medicine attended the 25th International Congress of Physiological Sciences in Munich July 25-31. The physicians included: **Gabriel G. Pinter, MD**, professor of physiology; **Raymond Sjodin, MD**, professor of biophysics; **Abram B. Fajer, MD**, associate professor of physiology; and **Paul J. DeWeer, MD**, assistant professor of biophysics.

Dr. Pinter has also been invited to speak at one of the satellite symposia on specialties that will follow this meeting—a symposium on renal function, to be held in Switzerland.

At the Switzerland meeting, Dr. Pinter will deliver a paper on "Functional Implications of Differences in Red Cell and Plasma Transit Through the Renal Medulla." The three co-authors of the paper are all at the School of Medicine: **Charles C. C. O'Morchoe, MD**, professor of anatomy; **Otis R. Blau-manis, MD**, assistant professor of physiology; and **D. L. Zisow**, a sophomore student who chose this work as his elective project and is continuing to work in Dr. Pinter's laboratory this summer.

While in Europe, Dr. Pinter will visit the laboratories of colleagues in Orsay, France; Leeds, England; and Glasgow, Scotland.

\* \* \*


Because sufficient students are not graduated from United States medical schools each year to staff America's enlarged number of hospitals, an increasing percentage of the interns and residents in American hospitals is foreign born. Graduates of medical schools abroad may arrive in this country without an adequate understanding of the phraseology or pronunciation of English, the language they will have to use when communicating with patients and hospital staffs.

One hospital in the United States, **South Baltimore General Hospital**, faced up to this problem ten years ago when the problem first became apparent. The student body of South Baltimore General Hospital's two-nights-a-week, 52-weeks-a-year "English Language School" changes constantly. Some physicians attend for six months, others for a year or two.

Classes have been held at the Baltimore medical facility since 1960 under the direction of **Clarence T. DeHaven, AB, MA**, Chairman of Speech and Drama at the Community College of Baltimore.

\* \* \*






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Probably, secondary to its hypoglycemic effect,  
decreases insulin oversecretion.  
This may help to reduce lipogenesis and facilitate lipolysis,  
which may account for the clinically reported  
loss of excess body weight and lowering of elevated  
serum cholesterol levels in overweight,  
hypercholesteremic, stable adult diabetics  
unresponsive to diet alone.



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- Thereafter** Continue effective DBI-TD dosage.

**To transfer from sulfonylurea therapy to DBI-TD alone:** The first week, withdraw sulfonylurea; start with DBI-TD as indicated in the chart.

**To transfer from sulfonylurea therapy to combined therapy with DBI-TD:** The first week, continue dosage of sulfonylurea; add DBI-TD as indicated in the chart. When effective regulation of diabetes is attained, sulfonylurea may be reduced and/or withdrawn.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions:** **Starvation Ketosis**, which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. **DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS.** **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones

in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331.** **Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.



## Doctors Take Note . . .

*Continued from page 12*

**OCTOBER 21-23, 1971**

### **AMERICAN COLLEGE OF PHYSICIANS**

Postgraduate Course—Diabetes—An International Review—The 50th Anniversary of Insulin: Indiana University School of Medicine, Myers Auditorium, Marion County General Hospital, 960 Locke St., Indianapolis, Indiana. Credit of 17¾ hours allowed toward AMA "Physician's Recognition Award." Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**OCTOBER 23-29, 1971**

### **ABRAHAM LINCOLN SCHOOL OF MEDICINE**

Annual Otolaryngologic Assembly of 1971—A Condensed Postgraduate Course: The University of Illinois Hospital Eye and Ear Infirmary. The course is designed to bring to specialists current information in medical and surgical otorhinolaryngology. For further information write: Otolaryngology, P.O. Box 6998, Chicago, Illinois 60680.

**OCTOBER 28, 1971**

### **NEW YORK STATE ACTION FOR CLEAN AIR**

Seventh Annual Symposium on Air Pollution and Respiratory Disease: Student Center of the Downstate Medical Center of the State University of New York, Brooklyn, N.Y. For further information, write: NYSACAC, 105 East 22nd Street, New York, New York 10010.

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# Baltimore County

## Medical Association

The members of the Baltimore County Medical Association spent an "Afternoon at the Timonium Race Track" on Wednesday, August 25, 1971. A plaque was presented to the owner of the winning horse in the seventh race by the president, John Krager, MD.

The annual crab feast will be held at Duffy's Restaurant on Wednesday, September 22 from 6 PM to 9 PM. All members and their spouses are cordially invited to attend. The crab feast will be held in the evening this year to allow more members to attend.

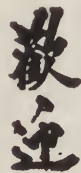
The staff of the Good Samaritan Hospital has invited the Association to lunch and a scientific talk on Wednesday, October 20. On Sunday, October 17, the members will attend the annual dinner-dance to be held at the Hunt Valley Inn this year.

In November, the Association will meet at the St. Joseph Hospital. Following an afternoon scientific session, the Woman's Auxiliary of the Baltimore County Medical Association will host a cocktail party.

The annual business meeting of the Association will be held at the Tail of the Fox on Wednesday, December 15. Members and their spouses will be invited to attend.

This completes the program for 1971. The Association wants to thank Herbert Levickas, MD, Vice-President and Program Chairman, for very interesting programs.

**Dorothy E. Holman**  
Executive Secretary



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# **ATTENTION — ALL PHYSICIANS IMPORTANT DATES**

**Wednesday, Thursday, Friday 3, 4, 5, May 1972**

## **174th Annual Meeting Medical and Chirurgical Faculty at the Baltimore Civic Center**

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- **Multiple Sessions for Specialties** to run concurrently
- **Plenary Session on a subject of common concern**, Chaired by  
John F. Schaefer, MD  
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- **Round Table Luncheon** dares to be different
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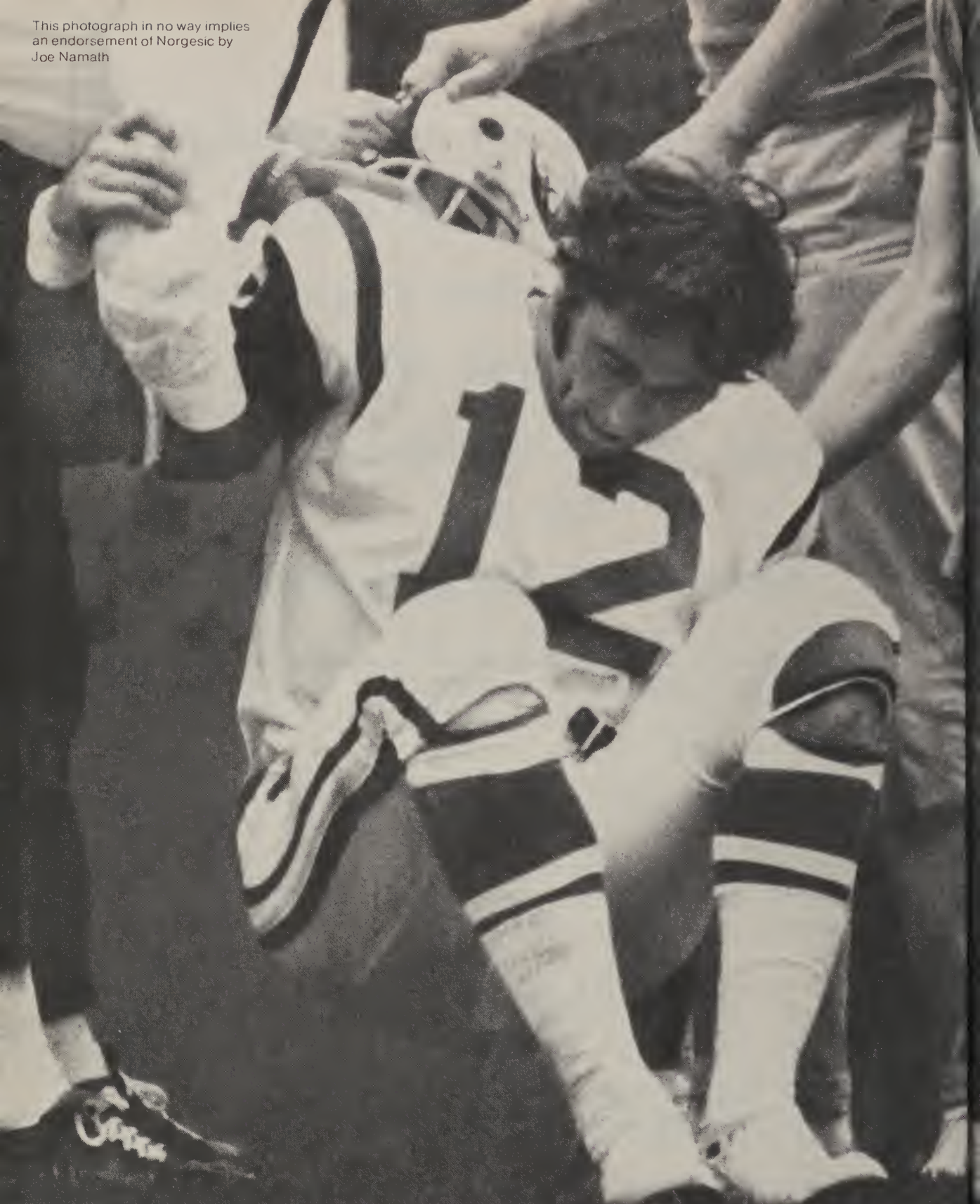
**WATCH THE JOURNAL EACH MONTH  
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**John B. De Hoff, MD, Chairman  
Committee on Program and Arrangements**

**SEE PAGE 40 for Scientific Exhibit application**



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Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon<sup>®</sup>).

**Warnings:** **USE IN PREGNANCY:** Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

**USE IN CHILDREN:** The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

**Precautions:** It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

**Adverse Reactions:** Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.

**Dosage and Administration:** Adults—1 to 2 tablets 3 to 4 times daily.

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## SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

3, 4, 5 May 1972  
Baltimore Civic Center

Ample space is available; however, it is suggested that applications be submitted as soon as possible.

### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO

NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: \_\_\_\_\_  
\_\_\_\_\_
2. Please attach a 50-100 word description of the exhibit: \_\_\_\_\_  
\_\_\_\_\_
3. Give amount of space required, depth, width, and height: \_\_\_\_\_  
  
If exhibit has side panels, are depth and width included above? \_\_\_\_\_  
  
If not, what additional space is required? \_\_\_\_\_
4. Electrical or other requirements: \_\_\_\_\_  
\_\_\_\_\_
5. Has exhibit been shown at other medical meetings? \_\_\_\_\_  
\_\_\_\_\_
6. Name and title of exhibitor: \_\_\_\_\_  
\_\_\_\_\_
7. Name of institution cooperating in the exhibit: \_\_\_\_\_  
\_\_\_\_\_
8. Address of exhibitor: \_\_\_\_\_  
\_\_\_\_\_

SEE RULES GOVERNING SCIENTIFIC EXHIBITS





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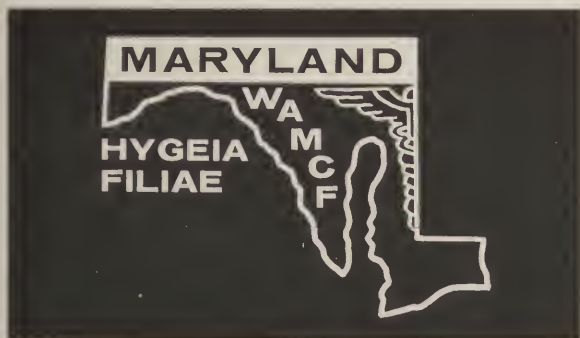
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MRS. WALLACE H. SADOWSKY, EDITOR

**woman's auxiliary**

## Report of the 48th Annual Convention Woman's Auxiliary AMA

This is the report given at the Auxiliary Board Meeting on June 30, 1971—held at the Med-Chi building, by Mrs. Marvin Kolkin, President-elect of the Woman's Auxiliary and Chairman of the Maryland delegation to the national convention.

The 48th Annual Convention of the Woman's Auxiliary to the American Medical Association was held June 20-24, 1971 in Atlantic City, New Jersey. A health message from President Nixon, a roster of prominent speakers, presentation of an Emergency Health Services award, and a record-shattering fundraising effort for medical education were a few of the high points of the Convention.

The Maryland delegation was comprised of Mrs. Robert Reiter, State President; Mrs. Raymond Yow, immediate Past-President; Mrs. Marvin Kolkin, President-elect; Mrs. H. Leonard Warres, Eastern Region International Health Chairman; Mrs. Francis Mayle, Recording Secretary; and Mrs. Leopoldo Gruss, Maryland International Health Chairman.

Serving as the continuing theme of the convention, and spotlighted in reports and addresses to the convention delegates, was "Adult Responsibility in Action". The fact that we of the Auxiliary are indeed active, responsible adults was well demonstrated throughout the meetings.

Walter H. Johnson, Jr., chairman of the board of Myers-Infoplan International, who delivered the keynote address at the opening session, entitled his remarks "From Adam's Rib to Woman's Lib".

"Technology forces the continuance of specialization, and women can be the great generalists. They

hold the thread of community continuity. They have time in which to change things and they who have given birth to society have a responsibility to see that it is a good one," Johnson declared.

"Be yourself, not the doctor's wife," said Mr. Johnson. "You don't need your husband to be you. You can keep the practice of medicine and the profession by applying your brains, energy and talents to communicating with people."

More praise was heaped on the Auxiliary members by Walter C. Bornemeier, MD, of Chicago, 1970-71 AMA President, when he told Auxiliary members, "I understand your membership goal for your 50th anniversary next year is 100,000. This country could use a million of you." He added that the auxiliary was "sowing the seeds of inspiration, of leadership and of example."

The most unforgettable moment of the convention came on Tuesday morning. Careful convention agendas and timetables were juggled so that we could greet and hear the President of the United States. In Mr. Nixon's address to the AMA House of Delegates, he enlisted the support of the nation's physicians in combating the monumental drug problem facing the country today. He also urged physicians to become involved in the medical politics and legislation of the day, stating that while a physician's pro-



fession must always come first, he will not have a profession as he knows it today if he does not become involved in relevant politics. Mr. Nixon also praised the work being done by the Woman's Auxiliary.

Apropos of these remarks, in this coming year, when we should certainly see the enactment of some form of federal medical legislation, the importance of joining the American Medical Political Action Committee was stressed during our meetings. In addition to the impact which our husbands can make by joining AMPAC to effect favorable legislation, it was pointed out that the addition of \$10 to the physician's AMPAC dues will convey membership upon his wife as well.

A major milestone was celebrated when Mrs. R. C. L. Robertson, 1970-71 Auxiliary president, presented a record-breaking check of \$550,927.01 to the American Medical Association Education and Research Foundation (AMA-ERF). Of the total,

\$437,565 was allocated as unrestricted funds for the nation's 113 existing and developing medical schools. Another \$62,033 was earmarked for the AMA-ERF loan guarantee program. We in the Maryland delegation were particularly proud of the County Achievement Award presented to the Woman's Auxiliary to the Montgomery County Medical Society. This county auxiliary made the largest contribution to AMA-ERF during this past year of all county auxiliaries in the 101-200 membership category. The efforts of the Montgomery County Auxiliary members and their husbands in this successful joint endeavor are to be applauded.

Also outstanding at the Auxiliary Convention's "Show and Tell" exhibits was the Maryland exhibit beautifully depicting our Project Hope Benefit. This outstanding artistic display caught the attention of the news media and will be featured in future publications.

Many excellent state reports were presented. The



Maryland physicians' wives attending national convention: (left to right) Mrs. M. McKendree Boyer, Mrs. Leopoldo Gruss, Mrs. Francis Mayle, Mrs. H. Leonard Warres, Mrs. Robert A. Reiter (president), Mrs. Raymond Yow, Mrs. William Stone, and Mrs. Marvin Kolkin (president-elect).



areas of activity which were stressed again and again in these reports were work in drug abuse, health careers, ecology, and community immunization programs.

An Emergency Health Services award from HEW was presented to the Oneida County, New York, Woman's Auxiliary for its outstanding achievements in an emergency medical identification program. This auxiliary distributed applications for tags to hospitals and physicians' offices. Upon receipt of an order, auxiliary members had the metal tags engraved with identification and emergency medical information, such as drug sensitivity and chronic illness or disease. In one year, 2,500 tags were distributed throughout New York at a cost of \$1 a tag. In addition to providing a necessary health service, the program engendered superb public relations.

Mrs. G. Prentiss Lee of Portland, Oregon, was installed as president of the auxiliary on Wednesday, June 23. She gave a stirring inaugural address in which she urged auxiliary members to commit themselves to the raising of the quality of personal and community health.

The convention was extremely stimulating and impressed one with the high caliber of Auxiliary work and workers. We eagerly anticipate the Auxiliary's 50th Anniversary Convention in San Francisco next year.



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According to the American Cancer Society, in 1971 there will be 75,000 new cases of carcinoma of the colon diagnosed.<sup>1</sup> During this same time period 46,000 deaths are expected. What can the medical profession do about this disease, which ranks as the most common visceral cancer in our country today? Although surgery is the mainstay in the treatment of colon cancer, no significant progress, as reflected by statistics, has been made in the surgical treatment in the last 25 years.

# **Etiological Aspects of Carcinoma of the Colon**

**ROBERT M. BEAZLEY, MD**  
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However, we should mention the "no-touch technique" of Turnbull,<sup>2</sup> although it is probably not a true breakthrough. Nothing new has been introduced, for by using the Turnbull's technique, the surgeon is forced to do a more complete and more extensive cancer operation, as has been recommended by many others. It seems reasonable that if we are to cure colon cancer, we must have some knowledge concerning its etiology in order to prevent the disease or to diagnose it in its earliest, most curable stage. When one considers carcinoma of the colon, etiology becomes mere speculation. However, in recent years some dramatic experimental and epidemiological work has been done which may shed some light on the etiology of carcinoma of the colon in our society.

Since the early 1960's a group of azo compounds—namely 1, 2-dialkylhydrazines, azo, and azoxyalkanes—have been used as carcinogenic agents in rats. In most animals, tumors of the colon can be induced in experimental model, utilizing these drugs either orally, subcutaneously, or intravenously.

The presence of the enzymatic alpha hydroxylation generally occurring in the bowel seems to be of key importance for the formation of the carcinogenic agent methyl diazonium (Figure 1). A weekly subcutaneous injection of 6 mgm per kilo of azoxymethane produced multiple adenocarcinomas of the bowel in all rats with induction period from 180 to 380 days.<sup>3</sup> Histologically, these tumors are very similar to human colonic tumors.



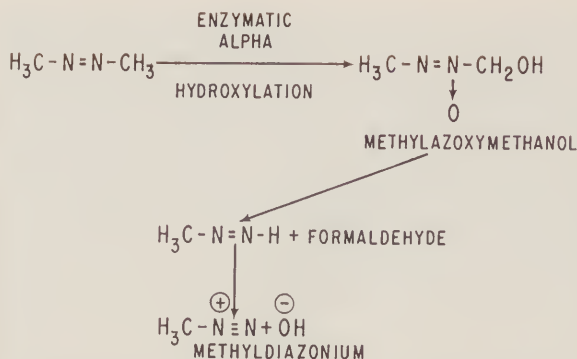


Figure 1: Metabolic Activation of Azomethane

The functions of colonic bacteria in carcinogenesis has been extensively investigated. Working with 3-2 dimethyl-4-amino-biphenyl (DMAB) investigators have found that after diverting colostomies were constructed, tumors failed to develop in the distal segment (normally the area with the highest incidence).<sup>4</sup> Additionally, the work of Laqueur has demonstrated that the naturally occurring plant carcinogen, cycasin, which degrades to methyl azoxymethanol, is not hydrolyzed in the gut of germ-free animals.<sup>5</sup> At the same time, germ-free animals are unaffected by total dosages of cycasin 25 times greater than that needed to induce colonic malignancies in normal rats.

Spatz and Laqueur were also able to demonstrate transplacental induction of intestinal tumors as a result of administration of cycasin to the pregnant rat.<sup>6</sup> Work with another carcinogen, acetylaminofluorene, which is secreted in bile, has shown that the germ-free animal, with its lack of hydrolyzing ability in the gut, excretes the conjugated compound unchanged. On the other hand, normal rats have a high concentration of the unconjugated metabolite in the colon and seem to develop many more tumors.<sup>7</sup>

Where does this animal work on chemical carcinogenesis leave us as physicians, faced with 75,000 cases of colon cancer each year? If taken in context, it should aid us to more adequately and intelligently interpret epidemiological data which has recently come to the forefront. What is known epidemiologically about carcinoma of the colon? It is well known that colon malignancy is much more common in Northern and Western Europe and in North America than it is in East Africa, Asia, and South America. Generally, areas with the lowest incidence, with the exception of Japan, have the lowest standard of living and those areas with the highest incidence have a higher standard of living. The geographical differences noted are not explicable on a racial basis since Japanese immigrants to California retain their low incidence experience provided they retain their original cultural habits, while second generation Japanese have a higher incidence. The process of Westernization whether in California

or in Japan, for that matter, seems to be associated with an increasing risk of colon cancer.

On the other hand, several studies have indicated a possible relationship of colon cancer to diet. It has been theorized that carcinogenic compounds may exist in cooked food such as benzpyrene derived from cooking oils and aflatoxins formed from molds. However, this theory does not adequately explain the geographical distribution of colon carcinoma. Observed differences might, however, be explained by a variation in the composition in the bacterial flora of the gut and whether or not the flora can produce carcinogens from the food or from the intestinal secretions. This theory has the added attraction that diet might exert an effect either by altering the supply of the substrate for carcinogen production or by altering the numbers and the nature of bacteria available to act on it. M. J. Hill and others have recently published a study entitled "Bacteria and the Etiology of Cancer of the Large Bowel."<sup>8</sup> In this report stools from six geographical areas were examined for content of bacteria and steroids. Fecal samples from the subjects in Britain, the United States, as well as Uganda, southern India, and a small village in northern Japan were examined. Basically, it was found that stool from Scotland, England, and the United States contained a greater total number of bacteria and considerably more gram-negative nonspore forming anaerobes (Bacteroides). On the other hand, the African and the Far-Eastern samples contained fewer total organism but more aerobic bacteria (Strept. Faecalis). When examining fecal steroids, neutral steroid content was low in Ugandans, Indians, and Japanese, while it was elevated markedly in both the British and American samples. Coprostanol and coprostanone, bacterial metabolites of cholesterol, were also elevated in the Western stool. Additionally, it was demonstrated that the breakdown of bile steroids was nearly ten times greater in the Western G.I. tract than in the African and Indian groups.

Dehydroxylation is the main bacterial metabolic pathway for breakdown of bile salts in the gut. Hill found that a significantly higher percentage of Western bacterial strains possessed the seven alpha dehydroxylase activity very important in bile degradation (Figure 2).



It has been postulated that the deoxycholate may be a carcinogen or a precarcinogen.<sup>9</sup> Furthermore, other metabolites of cholic acid, namely apocholic<sup>10</sup> 3β-acetoxybis nor Δ<sup>5</sup>-cholenic acid<sup>11</sup> have been shown to be carcinogens. Evidence also has been presented suggesting that the steroid nucleus of deoxycholic



acid can be converted to methylcholanethrene by the action of intestinal bacteria.<sup>12</sup> Hill has calculated the total cumulative dose of the deoxycholic acid passing through the colon in 56 years might be some 1,300 gm, and he suggests that it need not be a very active agent to account for the 17/100,000 incidence of carcinoma in the United States.

These laboratory and epidemiological studies, correlated with the clinical work Mr. Denis Burkitt presented at the National Conference on Colon and Rectal Carcinoma held in San Diego, January 1971, seem to shed a gleamer of light on the etiology of colonic carcinoma.<sup>13-14</sup> Briefly, Burkitt was able to show by the simple technique of feeding barium-impregnated plastic pellets to South African Bantu natives that the transit time of the Bantu is significantly less than the transit time of the Westerner. Stools were collected in plastic bags and X-rayed. The number of barium-containing plastic pellets were counted and accurate transit times were determined. Additionally, the stools were weighed and volumes were ascertained by water displacement.

A similar study was carried out in a British public school setting where the normal diet was found to be of much lower residue. Transit times were elevated into the range of three to five days as com-

pared to 15 to 25 hours in the African Bantu. Stools were of low-volume and of low-weight and had a very high bacterial content when compared to the African stool. Mr. Burkitt concluded his remarks by stating that he felt that colon carcinoma was related to the low residue Western diet and possible contained carcinogens. In addition, he felt the effect of the carcinogen was enhanced by the fact that transit times were markedly prolonged allowing the carcinogen a much greater contact time with the mucosa. It was stressed that in countries where the diet contains large quantities of partially refined or unrefined grains and fibers, resulting in a high residue diet, carcinoma of the colon, appendicitis, and diverticulosis coli are quite uncommon.

By correlating the animal, biochemical, and epidemiological work it should not be difficult for one to sense a trend concerning the etiology of carcinoma of the colon. There is strong evidence to suggest that etiology is basically related to dietary carcinogens and that these carcinogens or precarcinogens are acted upon by bacteria peculiar to the Western gut. These factors compounded by the prolonged transit time of the Western gut may function as the major elements in the etiology of carcinoma of the colon.

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# Medicine in Maryland in the 17th and 18th Centuries

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*"The Renaissance Ideal of man is charmingly set forth in Richard Brothwaite's The English Gentleman (1630), 'containing sundry excellent rules, or exquisite observations, tending to direction of every gentleman, how to demeane himself or accomodate himselfe in the manage of publike or private affaires . . .' Who but must admire the well-rounded man, proficient in every art and skill, yet never proficient to the point of vocationalism, learned without pedantry, a poet, a courtier, a dancer, a musician, a Latinist, a lover . . ."*

*Howard Mumford Jones—O Strange New World*

The major source of information on medicine in Maryland in the seventeenth century resides in the *Archives of Maryland*. Little is available about everyday medical practice; we have available only the selected material which was brought before the courts for required legislative action. Quinan<sup>1</sup> and Steiner<sup>2</sup> have mined some of this information. A thorough study of this rich source could yield a unique body of medical-social information. This paper is based on a review of the *Archives of Maryland*, together with a summary of the few secondary writings on this period.

## Early Physicians in Maryland

Henry Kenton was the first English physician to set foot on the American continent, accompanying the expedition of Captain Bartholomew Gilbert up the "Chesepian" Bay in 1603. Kenton and four companions were killed by Indians when they went on an exploratory expedition.

Walter Russell, physician, accompanied John Smith on his exploration of the Chesapeake Bay in 1608. The account of this exploration was written by Russell and Amos Todkill.<sup>3</sup> They reached the Patapsco River in June of 1608. Watts Islands in the Chesapeake were originally called Russell Islands after Walter Russell. Russell treated John Smith for a stingray wound: "But it chanced, the Captaine taking a fish from his sword (not knowing her condition), being much of the fashion of a Thorne-

backe with a long taile whereon is a most poysoned sting 2 or 3 inches long, which shee strooke an inch and halfe into the wrist of his arme: the which in 4 houres, had so extremely swolne his hand, arme, shoulder, and part of his body, as we all with much sorrow concluded his funerall, and prepared his grave in an Ile hard by (as himselfe appointed) which then wee called Stingeray Ile, after the name of the fish. Yet by the helpe of a precious oile, Doctour Russel applyed, ere night his tormenting paine was so wel asswaged that he eate the fish to his supper; which gave no less joy and content to us, then ease to himsilfe. Having neither Surgeon nor surgerie but that preservative oile we presently set saile for James Towne."<sup>4</sup>

The duties of the physician as opposed to those of the surgeon are clearly outlined in this early narrative.

Smith's second Chesapeake exploration was also described by a medical man, Anthony Bagnall, chirurgeon. Bagnall himself, shot through the hat and sleeves by Indians, inflicted more severe injuries on the Indians and then treated the wounded ones. This expedition started the long tradition of waterfowl shooting on the Chesapeake, three men killing 148 waterfowl with three shots.

Henry Hooper, chirurgeon, was the first medical man to settle in Maryland in 1637. Hooper contracted with the colony for military medical service. In 1644 he demanded payment of 3,379 pounds of tobacco and three pounds of corn due him for "sal-



lary and chirurgery in the fort of St. Inegoës.”<sup>2</sup> We do not know how well his medical practice prospered over the next few years, but a curious contract made with the governor in 1646 suggests that Hooper became the first geographical full-time salaried physician in the colonies: February 4, 1646. “Acknowledged this day in Court to be agreed by the governor for a Twelve month from this day in the quality of a Chirurgeon and the governor is for it to find all druggs and to find him with diett and lodging and to allow him two-thirds of all accounts which the Chirurgeon shall earn by his practice in the colony during the said time”.<sup>5</sup>

Several other interesting vagaries of medical practice with a modern ring are mentioned in the early Maryland records: In 1640 a wage regulation law,<sup>6</sup> *An Act for Rating Artificers Wages* was passed:

“The County Court may moderate the bills and wages of artificers, laborers and chirurgeons according to the most current rate of Tobacco proportioned to the rates of the price of the same or the like art, labor or workmanship in England.”

Several items suggest that contracting for total medical care was an accepted method of health care in early Maryland: In 1659, Dr. Luke Barber had agreed<sup>7</sup> “to serve and supply said Harris and his family with physic and other medicines touching his practice from March till August following for 1,000 pounds of tobacco.” Harris had died and his wife had married William Henry Coursey, who refused to pay the fee, so that Dr. Barber brought suit against Coursey.

Between 1637 and 1661, 24 medical men arrived in Maryland.<sup>3</sup> They were called physicians, chirurgeons, and licentiates in physic. There were at least three barber-chirurgeons.<sup>2</sup> Many of these men did not practice medicine, once established in the colony. Thomas Gerard, the most prominent physician of the time, came to Maryland in 1638, and became a member of the Assembly between 1639 and 1643. He was named to the Council in 1643. A devout Roman Catholic, he was initially loyal to Lord Baltimore, but later was banished with the notorious Josias Fendall. Later he was pardoned.

The early physicians used European drugs such as myrrh, saffron, ginger, cinnamon, frankincense, garlic, mustard, birthwort, galbanum, castor, gum arabic, opium, gentian, valerian, and acacia. The attempt to develop local herbs and Indian cures came at a later period.<sup>2</sup>

#### Coroners, Inquests and Murders

Inquests into cause of death were common in the early life of the colony. On January 31, 1637 the death of John Bryant by a falling tree is recorded.<sup>8</sup> The tree was found guilty and the coroner's jury “had said tree forfeited to the Lord Proprietor”.

The first autopsy reported in the colonies<sup>9</sup> was performed on an Indian, Edward, who had been

shot by a blacksmith, John Dandy. It is interesting that the boy, who lived three days, was baptised and christened Edward by the local Roman Catholic priest after his injury. The autopsy report stated that the “bullet entered the epigastrium near the navell on the right side, obliquely descending and piercing the gutts, glancing on the last vertebra, and was lodged in the side of Ano”.<sup>10</sup>

Dandy pleaded not guilty, but was convicted of murder and executed in March of 1643.

The first act to regulate coroners' fees was passed by the Assembly in 1671. Coroners were to be paid 250 pounds of tobacco “for their viewing the bodyes of any person or persons murdered, slayne, drowned or otherwise dead by misadventure”.<sup>11</sup> This fee was to be paid out of the estate of the person murdered. There were complaints that the coroners were tardy in viewing the body. The coroner's oath was that of service to the Proprietor and the people.<sup>12</sup>

A murder mystery is reported in 1648.<sup>13</sup> Thomas Allen was “fowned dead upon the sands of Poynt Looke out in St. Michael Manor. Thomas Allen was shott under the right shoulder, and hath three holes but whether with Shott or Arrowes they know not. His corps is so eat and consumed. And likewise that a great piece of his scull is broken and taken away; and the skin of his scull is flayed of quite round his head.”

The description suggests that Mr. Allen was killed with arrows and scalped. The scalping was done so crudely that it raises the question of whether the murderer was trying to make it appear that Indians had done it.

The most remarkable aspect of the case was Allen's will, which directed that if he suffered a sudden and unexpected death, he wanted “Nick and Marks att Pyneyneck, Irish men, questioned as suspicious men: for reasons to mee best knowne”. Unfortunately, we have no subsequent history of whether the murderers were apprehended.

#### Cool Springs

The search for medicinal waters began in the colonies about 1700. By 1744 they were a fashionable indulgence.<sup>14</sup> Stafford Springs in Connecticut, Bristol, northeast of Philadelphia, and Berkeley Springs in Virginia were visited to combat gout, phthisis, the vapors, arthritis, and depression. In 1810, the Bladensburg Spa was a favorite afternoon drive from Washington, D.C.<sup>15</sup> Later in the nineteenth century a series of springs arising on the eastern slope of the Allegheny Mountains served as summer resorts for the upper classes. These springs included Warm Springs in Georgia, Hot Springs, White Sulphur, Capon Springs, Berkeley Springs in Virginia, Bedford Springs in Pennsylvania, Saratoga Springs in New York, and Poland Springs in Maine.

Cool Springs in St. Mary's County (near Charlotte Hall) must have been in use for a number of years



before the Legislature recognized it as a special resource of the colony. It is first mentioned in a general thanksgiving proclamation by the Legislature on October 22, 1698. "Thanksgiving is rendered to the Almighty because of the many wonderful cures amongst several distempered and important persons which Cool Springs hath wrought." It is possible that an epidemic in the previous year in Charles County had focused attention on sickness and disease and had increased the use of Cool Springs by the sick.<sup>16</sup> In any case, the governor announced (October 22, 1698) that he had received inquiries from New York in regard to the medicinal qualities of Cool Springs. He recommended that a small tenement in the nature of a hospital be built, with heat and other necessities. He offered 25 pounds of his own as a starter.<sup>17</sup>

There must have been some skepticism on the part of the Legislature concerning the healing properties of the springs, because on October 23, 1697, the Council directed that an investigation be made as to what distempers and persons had been cured. This information was to be collected under oath and transmitted to the governor.<sup>18</sup> Such evidence was collected<sup>19</sup> and the governor contributed ten Bibles to the poor, flocking to the springs. He ordered the appointment of "some Sober Person" to read prayers twice daily. The governor supplied "A Book of Homilys, two books of family Devotions and a Book of Reformed Devotions written by Dr. Theophilus Dorrington out of which Books he is to read to them on Sundays". The governor also directed that the poor people be given a "Mutton and as much Indian Corn as will Amount to thirteen Shillings per Week" at his own expense.<sup>20</sup>

It was decided to buy 50 acres of land including the springs. A committee was appointed to draw up an enabling act. Over the next month, the bill

was passed, Trustees were appointed, money was appropriated, and the bill signed by the governor. The building of the tenement "for the entertainment of such lame diseased persons as shall restore thither for cure" was financed.

The real trouble began when the owner of the land was approached. He must have been unwilling to sell his land from the start. The trustees originally talked him into selling the land for 25 pounds, but they were not sure he would honor the agreement, so they recommended that the conveyance of land be completed promptly. They made a special trip to John Dent's house with the conveyance document, two justices of the peace were called in as witnesses (July 8, 1799); but, John Dent refused to sign.

Dent's lack of cooperation may have been the result of the refusal of the Legislature to allow him a special free license to run an ordinary at Cool Springs.

It then became necessary to condemn the land and establish a fair price.<sup>21</sup> The governor himself wished to see the layout of the land and select the proper place for the tenements.<sup>22</sup>

Like so many other medical projects, we do not know the ultimate fate of the Cool Springs Project. It was one of the earliest attempts to treat the chronic diseases of poor people. The Governor's interest and personal contributions contrast with the local landowner's attempt to extract all he could from his land, the tourist, and sick trade.

Hall Pleasants, MD, has suggested that Cool Springs was the second hospital in the colonies.<sup>23</sup> He visited the springs in 1889 and found them nearly forgotten by the oldest inhabitants. In view of the fact that physicians were never associated with the Cool Springs and that there is some question as to whether the tenements were ever erected, the designation of hospital seems inappropriate.

## The Eighteenth Century

*"If a doctor imagined that his reasoning had the value of a mathematician's, he would be utterly in error and would be led into the most unsound conclusions. This is unluckily what has happened and still happens to the men whom I shall call systematizers. These men start, in fact, from an idea which is based more or less on observation, and which they regard as an absolute truth. They then reason logically and without experimenting, and from deduction to deduction they succeed in building a system which is logical, but which has no sort of scientific reality."*

**Claude Bernard (1813-1878)—An Introduction to the Study of Experimental Medicine**

The eighteenth century marks the beginning of the end of dogma and deductive reasoning in medi-



cine, the start of observation and inductive reasoning. Thus we find some publications of Maryland physicians nearly completely deductive, others almost totally inductive. In brief, the eighteenth century marked the beginning of the introduction of the scientific method into everyday medical practice. There was still a struggle between the European educated physician and the pure empiric self-educated colonial physician. The former emphasized the intellect, the medical literature, and tradition as essential to medical practice. He wrote the scientific articles and represented the profession in the public eye, supported state licensure and medical education. The self-trained empiric, on the other hand, was fulfilling a need for physicians and generally was accepted uncritically on his own word.

Although the empirics, apprentice training, proprietary medical schools, and diploma mills persisted up to the twentieth century, the intellectual climate began to turn against them as early as the middle of the eighteenth century. The American Philosophical Society (1743), and the American Academy of Arts and Sciences (1780) were forerunners of the state medical societies and faculties (New Jersey State Medical Society, 1766). The founding of hospitals (Pennsylvania Hospital, 1751), medical schools (Philadelphia, 1765; New York, 1768; Boston, 1783) and medical magazines (*Medical Repository*, 1797) were all fruits of the new Enlightenment, which developed and flourished up to the present.

#### American Medical Literature of the Eighteenth Century

The medical literature of the eighteenth century in America offers a primary, largely unexplored source of medical-social knowledge. The diseases reported, the physicians who wrote, the media used, all give direct information. Just as men are the product of their times, so is the medical literature. Thus the earliest example of Colonial medical literature (1677), written by Rev. Thomas Thatcher (1620-1678), was directed to the people ("A Brief Rule to Guide the Common People of New England") in an attempt to meet a practical problem ("How to Order Themselves and Theirs in the Small-Pocks or Measles").

This first treatise was written by a divine because there were no physicians. Where there were no educated people, a local inhabitant often acted in the capacity of physician or dentist. These enforced physicians were interested purely in practical problems. Alexander Hamilton, MD,<sup>25</sup> in 1744 reports meeting a blacksmith who was the local tooth extractor. Later an apprentice system grew up around local physicians, finally leading to the formation of medical schools. Early physicians often used the newspapers as a means of communicating practical knowledge to the people. By the eighteenth century, Ameri-

can medical articles were being published in the *Philosophical Transactions of the Royal Society of London* next to articles on weather, geography, new species of animals, and other general scientific matters.

By 1776, 18 medical works had been published in Philadelphia; only three were reprints. Of the 176 medical journals published before 1800, only one was published in the American Colonies.

#### Maryland Medical Literature of the Eighteenth Century

Although writings of Maryland physicians of the eighteenth century are not voluminous, they are extensive enough to reveal many of the important medical problems, practices, theories of disease, treatment, and types of diseases seen.

An invaluable document is Dr. Hamilton's diary<sup>25</sup> of a trip in 1744 from Annapolis to Maine and back, revealing social practices, introducing us to the leading physicians of the colonies, and giving an insight into the type of men practicing medicine at the time.

A ribald pamphlet<sup>26</sup> from the pen of the same Dr. Hamilton is an example of medical controversy of the time, with its coarse invective, personal attack, and earthy poetry.

Several letters<sup>27-28</sup> from the Province of Maryland to the editor of the *Philosophical Transactions of the Royal Society of London* at mid-century by a Maryland-born physician and surgeon (Mr. Richard Brooke) "lately in London" gives a general weather report for the year 1753, revealing the belief that disease was associated in some way with hot weather and water. There is also a case report on hydrophobia by Brooke,<sup>29</sup> a description of the habits of the ruffed grouse,<sup>30</sup> and a new method of inoculation,<sup>31</sup> all showing that some physicians of the day had wide scientific interests.

Brooke also published five reports in the *Gentleman's Magazine* between 1752 and 1763 on the use of lightning rods, a prescription to destroy lice in children's hair, a cat which suckled a young rat, and an attack on the Proprietary Government in Maryland in 1763.

A case report<sup>32</sup> by John Bate, MD, in 1752 of a Negro woman turning white is a remarkable example of that rare commodity—description without quoting authorities or theories. Indeed, there is a request for suggestions as to what experiments might be done to elucidate the situation.

Both Brooke and Bate report pure observations, without any recognition of the ancient authorities or references to past opinions.

An anonymous physician reports in the local newspaper<sup>33</sup> what was probably an epidemic of typhus fever in Talbot County in 1764.

The first medical monograph<sup>34</sup> by a Baltimore



physician was published in 1789 on the subject of typhus fever. Here are presented the types of fever, the cause of the disease and use of drugs in its treatment. Possibly the most remarkable feature of the *Treatise* is that it contains no evidence that the author himself has ever seen a case of the disease he is describing. Furthermore, in quoting extensively from the authorities, he makes no effort to evaluate their opinions critically. The *Treatise* is typical of most of the medical writing of the eighteenth century with its curious disregard for first-hand observation, case reports or new ideas.

Dr. Thomas Drysdale's *Yellow Fever in Baltimore in 1794*<sup>35</sup> was not published until 1804, six years after his death. Here the problem of contagion is ably presented.

A second monograph on yellow fever is that of Joseph Mackrill, MD, in 1796.<sup>36</sup> This is the first Maryland publication by a French-trained physician from the West Indies.

The anonymous (a gentleman of the Faculty) reply to Dr. Mackrill<sup>37</sup> was published in 1796 and is an obsequious vindication of Dr. Rush. It is also an attack on Dr. Mackrill's insistence on a strict quarantine. In these two publications the controversy as to whether yellow fever is a contagious (communicable from person-to-person) or infectious (arising from decaying vegetable matter) disease is discussed extensively. Mackrill thought the disease contagious, but only in a stinking, confined, hot atmosphere. The disease should be combatted by proper cleaning of streets and draining of ponds.

A fourth report<sup>38</sup> on yellow fever by H. Stevenson appeared in 1797 in the local newspaper.

In 1798, John B. Davidge published a monograph<sup>39</sup> on yellow fever.

Prior to 1800, there was only one medical journal in the United States—the *New York Medical Repository*. This journal was available to all American physicians and the Report of the Commissioners of Health to the Mayor and City Council of Baltimore was published in the first volume in November, 1797.<sup>40</sup>

The transactions of the Harford Medical Society 1797-98 give a regrettably brief yet luminous and vivid account of a small group of enthusiastic physicians meeting at the house of their mentor to discuss recent advances in medicine at distant medical centers.<sup>41</sup>

Perhaps the most important scientific article published by a Maryland physician in the eighteenth century was the last one, that by Andrew Wiesenthal in 1799 on a protozoan infestation of chickens, the first description of a parasite causing a disease.<sup>42</sup>

#### Disease in Maryland in the Eighteenth Century

Maryland medical writings of the mid-eighteenth century were largely concerned with inoculation for

smallpox.<sup>26, 31</sup> Starting in 1764<sup>33</sup> and reaching a crescendo in the last decade of the century,<sup>35-40</sup> yellow fever took over the center of interest. These diseases received a great deal of attention because of their sudden unexpected appearance and their high mortality.

The two most common debilitating lethal diseases of the colonies, malaria and dysentery,<sup>43</sup> are mentioned only in passing in eighteenth century Maryland medical reports.

From earlier times, it was noted that diseases were of two types, those with fever and those without. The great epidemic diseases, especially, were associated with fever. The febrile diseases were particularly dramatic, in that they struck the young most often, were frequently lethal, disrupted whole communities, and seemed to arrive and leave with no explanation. By the latter part of the eighteenth century, it was apparent that the febrile diseases might be divided into a number of types. The association of some febrile diseases with certain seasons, and special locations, the nature of the fever (whether continuous or intermittent), and whether the disease seemed to spread from person to person were all matters of great interest.

The humoral theory originated long before Hippocrates, but he organized the theory. Galen added to it. Some variation of the humoral theory was held by physicians of the eighteenth century although it was an age of new arrangements. The therapeutic aim of its practitioners was to restore a harmonious balance of the humors which were assumed to have broken down in various ways. Diseases, therefore, were assumed to be generalized, although it was freely recognized that injuries and wounds were local.

During the latter part of the eighteenth century, there was a gradual standardization of the meaning of certain words used in connection with febrile diseases. Of great practical importance was whether a fever was or was not transmitted from person to person either directly or indirectly. Contagious (contango, touch) diseases were thought to be spread from the sick person in his breath, secretions or excretions to the skin, lungs, or stomach of the contact. The noxious substance so conveyed from the sick to the well was thought to be a breaking down (putrefaction) of something within the body of the sick person. This substance was specific for the disease and produced immunity against it in the future.

Infectious (inficio, to spoil) diseases, on the other hand, were caused by decay of dead organic material. From the decaying matter a harmful gas (effluvia or pabulum) was given off, but spread only in an impure atmosphere. There were numerous variations on these two major themes.

By the end of the eighteenth century smallpox, scarlet fever, measles, whooping cough, mumps, and



hydrophobia were generally accepted as contagious. Pulmonary tuberculosis, typhus, malignant sore throat (diphtheria), and the dysenteries were believed by some to be contagious, by others not.

The infectious disease par excellence was malaria (mala aria, bad air) arising from decaying vegetation in swampy areas. Some authorities included typhus fever as an infectious disease.

The ancient distinction between contagious and infectious diseases had great practical importance, not only for health officers, but also for commerce and travel between nations and cities. For if a disease were contagious, it was spread only by contact with a person. Quarantine laws were therefore necessary; commerce and travel were discouraged. These measures, if enforced, could cut off the economic life of a city.

Infectious diseases, on the other hand, arose from decaying vegetation or animal matter in an atmosphere conducive to carrying the effluvia. Such atmospheres were the miasmata of poorly drained swamps. Such diseases did not need to be quaran-

tined; the areas where they arose had to be cleaned up of refuse and decaying matter and drained.

In time, the word contagion has come to refer only to a mode of conveyance of disease, namely by close contact. Infection, on the other hand, has taken on a much broader meaning to encompass a large group of diseases characterized by fever, tachycardia, and inflammatory lesions caused by a micro-organism. Such diseases are capable of transmission by any means, close contact (contagious), by droplet, feces, vector, or injection.

Largely as a result of yellow fever epidemics, organized health departments arose to combat this problem. In 1792 in Baltimore, John Ross and John Worthington were acting as quarantine physicians, serving under a Committee of Health. In 1793 the Maryland Legislature passed an "Act to appoint a health officer for the part of Baltimore-town" (signed into law by the Governor Dec. 28, 1793).

With the incorporation of Baltimore into a city on Jan. 1, 1797, a board of health was included as a branch of city government.

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The lung, by virtue of its structure, can respond to insults in a strictly limited number of ways, whether the insult is bacterial, viral, or chemical. This applies as much to signs and symptoms caused by the insult, as it does to the tissue response evoked. Thus, there are very few pathognomic symptoms and signs encountered in chest disease. Those few that exist usually indicate the rare and esoteric, rather than the common disease which the family practitioner is likely to encounter.

# Useful Symptoms and Signs in Chest Disease

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The response of the lungs to injury or insult is to cause the patient either to cough, to feel pain, to be short of breath, to wheeze, or to expectorate blood or sputum. None of these symptoms is specific and, moreover, some may occur in disorders of the other systems, particularly heart disease. Nevertheless, diligent attention to the manner in which these symptoms appear, to their association with constitutional symptoms, and in particular to their relationship to each other, provide a basis for diagnosis in more than 50% of patients with chest disease. Thus, a history of paroxysmal shortness of breath accompanied by wheezing in a young adult should suggest a diagnosis of asthma, despite the fact that at the time the patient is seen he may be without either signs or symptoms. Let us consider some of the common pulmonary symptoms and how they originate.

In the lung there are three types of receptors: cough receptors, irritant receptors, and the less well understood J receptors. The cough receptors are situated in the trachea and main stem bronchi. They are stimulated by a variety of insults and the patient, no matter how the insult is caused—by fluid, gas, or solid—responds by coughing. This is a protective mechanism and an effective means of getting rid of extraneous irritant material.

The irritant receptors likewise respond to a variety of insults, but are more responsive to gaseous or fine particulate matter. They are situated in the smaller bronchi and terminal bronchioles. When they are stimulated the patient undergoes vagal hyperpnea, bronchoconstriction, and may feel dyspneic. These effects are a consequence of histamine liberation and are mediated through the vagus nerve.

The exact function of the J receptors is uncertain, but they are situated in the lung parenchyma, ie, in the secondary lobule and distal to the terminal bronchiole. As far as is known, the patient whose J receptors are stimulated in the absence of stimulation of his cough and irritant receptors feels a deep-seated pain in his chest but has neither wheeze nor cough. Needless to say, it is only small particles or gases, those approximately around  $5\mu$ , that can reach the lung parenchyma and, hence, produce this effect.

### Symptoms

**Pain:** The most common type of pain experienced by patients with lung disease is pleurisy. Its characteristics are well known—the worsening with coughing and breathing and the associated splinting of the chest. What is less well known is the fact that pleural pain may be referred to sites some distance from the pathological process. It should be remembered that the parietal pleura only is sensitive and that the visceral pleura can be lacerated, burnt, or diseased and no pain is felt. The parietal pleura of the chest wall derives its sensory innervation from

the intercostal nerves. Thus, pain resulting from inflammation of the parietal pleura is accurately localized to that part of the chest supplied by the appropriate intercostal nerve.

With the diaphragmatic pleura, things are different. The sensory innervation of the periphery of the diaphragm is derived from the lower six intercostals; hence, when this part of the diaphragm is involved by disease, the pain is frequently referred to the upper abdomen, the flank, or even the iliac fossa. The central portion of the diaphragm receives its sensory innervation from the phrenic nerve. Therefore, pleurisy in this region is referred to the third, fourth, and fifth cervical dermatomes, viz, the shoulder tip and scapular region. That portion of the pericardium which is in contact with the diaphragmatic pleura has a similar innervation, and pericardial pain is often mistaken for pleurisy since it is worsened by breathing and in addition may be referred to the above mentioned areas.

**Cough:** This is the most nonspecific symptom of all; however, much can be learned from its character, frequency, and mode of onset. It is important to know whether the cough is dry or productive, how long it has been present, whether it is nocturnal, and whether it is associated with other symptoms such as shortness of breath or wheeze. The patient who repeatedly wakes up at night with a severe coughing bout should be suspected of having esophageal disease and dysphagia pneumonitis.

**Wheeze:** Sometimes a patient will notice that his chest is wheezy. This observation is frequent in asthma, especially when concomitant shortness of breath is present. Despite the fact that many textbooks of physical diagnoses make a point of differentiating wheezes from rhonchi, the terms are actually interchangeable. A wheeze is produced by turbulent flow in the dead space—in any of the bronchi down to the terminal bronchiole. Wheezes may be high-pitched and musical, in which case some people call them sibilant rhonchi, or they may be low-pitched and honking, in which case some call them sonorous rhonchi. The wheezes commonly heard in asthma and chronic bronchitis are usually present over most of the lungs; however, occasionally a localized wheeze is present. The persistent hilar rhonchus (or wheeze) that occurs in the 50-year-old man and persists after coughing almost always indicates a bronchogenic cancer. Frequently, it can be palpated as well as heard. In younger patients, a persistent hilar wheeze may indicate bronchial obstruction due to an adenoma, tuberculous lymph nodes, or a foreign body.

**Hemoptysis:** The causes of this symptom are legion, both pulmonary and cardiac. Furthermore, in some subjects no cause is found. When localized lung disease can be seen in a chest film in a subject with hemoptysis, it is reasonable to assume a cause-and-



effect relationship. If no lesion is present on the film, occasionally no cause for the hemoptysis is found.

### Physical Signs

Again, few physical signs are specific, but in association with the history, some are most useful pointers.

**Tachypnea:** Nurses, despite the fact that they have forsaken nursing for education and degrees, can often count a pulse and take a temperature reasonably accurately. Seldom do they bother to count respirations unless the patient is in obvious respiratory distress, in which case they record, and often fairly accurately, that the man with respiratory failure has a rate of 24 to 30. However, the subject with a diffusion fibrosis who has a respiratory rate of 35 at rest in the absence of dyspnea, always has his rate recorded as approximately 16. This results from the fact that since the man is apparently in no distress, his respiratory rate must be 16; a fact which intuition tells them must be so. Therefore, there is no need to count the respirations. The patient who has a respiratory rate of 34 to 40 at rest, but who is not short of breath, usually has "alveolo-capillary block." His symptoms may be minimal at rest but with moderate exercise may become profound.

**Wheeze:** This has already been discussed, since it is often a symptom as well as a sign. The only additional point that is necessary to make is the frequency with which forced ventilation—panting or a forced expiration—will bring to light a wheeze that was not audible during quiet respiration. This physical sign is often useful in recognizing asthma when the latter is in remission.

**Rales:** These signs originate in the lung parenchyma. According to most textbooks of physical diagnosis, they are produced by air bubbling through fluid filled alveoli. This explanation, despite its popularity, is obviously inaccurate. Are we to assume that the transient rales heard after sleep are due to fluid, and that the fluid disappears after the subject takes a deep breath? Does the obese subject have fluid at his bases which clears with a deep breath? Obviously the air bubbling through fluid theory is erroneous. In reality, rales are produced by the popping open during inspiration of respira-

tory bronchioles that have been collapsed and not in use. This same mechanism explains the rales heard in pneumonic consolidation, in atelectasis and in pulmonary edema. The disease where rales are heard so persistently and profusely is chronic interstitial fibrosis of the lung (fibrosing alveolitis). We know from the histology of this disease that no fluid is present in the alveoli. Finally, rales should be described as coarse, medium, or fine. All the other choice epithets, eg, tenacious, tacky, moist, dry, crepitant, and succulent, that were and are still used by the older diagnosticians, should be purged from our vocabulary. All they did was introduce confusion, and cover the user's ignorance with meaningless but high-sounding terms.

**Hamman's sign:** A loud cracking noise synchronized with each heartbeat and often audible from the foot of the bed and which originates from behind and to the side of the sternum indicates mediastinal emphysema. It usually develops spontaneously and is as frightening to the neophyte physician as it is to the patient. Patient and physician are best treated with either a stiff Scotch or a small dose of phenobarbital. Hamman's sign is generally far more impressive than it is serious.

**Subcutaneous emphysema:** The appearance of subcutaneous emphysema of the chest after injury usually indicates rupture of the trachea or bronchus, or severe damage to the lung. The appearance of mediastinal and subcutaneous emphysema associated with the onset of severe retrosternal and pleuritic pain after an attack of vomiting strongly suggests spontaneous rupture of the esophagus. This is a surgical emergency which can be successfully treated if diagnosed promptly.

### Investigations

Signs and symptoms go a long way in helping to diagnose most chest illnesses; however, tuberculosis is a notable exception. In this condition, the chest film is of paramount importance. Otherwise the eclectic use of bronchoscopy, the plain chest film, bronchography, tomography, sputum examination, and pulmonary function tests can, coupled with a good history and physical, make the diagnosis 95% of the time. Multiphasic screening seldom helps in the diagnosis of chest disease, or any other type of disease.





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An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>2</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>1</sup> was about sevenfold, while Sartwell and associates<sup>2</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of

them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfolobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>2</sup> uptake values; metyrapone test and pregnanediol determination.

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## Baltimore City health department

# Progress Notes

## TB X-ray Drive

Allan S. Moodie, MD, Director of the Bureau of Communicable Diseases, reports that this summer's "To Beat the Bug" campaign against tuberculosis was highly successful. Scheduled from June 21 to July 31, more than 18,000 persons were X-rayed in two X-ray vans at various locations in the city.

The campaign was conducted by the Inner City Interagency Task Force Against Tuberculosis under the chairmanship of Mr. Phaion Hyche, II, of the Model Cities Agency. The objective of the drive which may become a continuing effort is to find unsuspected tuberculosis particularly in inner-city areas, with particular emphasis on the nonwhite male, 25 years of age or above, in which group the

incidence of tuberculosis is ten times the national rate. Assistance was provided by the Community Action Agency, the Model Cities Agency, the Baltimore Urban League, Provident Hospital Comprehensive Center, the City and State Health Departments, the Maryland Tuberculosis and Respiratory Disease Association, and the Ministerial Alliance.

The "To Beat the Bug" campaign in 1970 found 21 active cases of tuberculosis. These patients were placed under treatment to remove them as sources of infection. Because of campaigns of this kind, Baltimore has dropped from first place among the large cities of the United States in new active tuberculosis cases to third place.

## New TB-Alcoholism Service

The City Health Department's Alcoholism Program and the Division of Tuberculosis have joined forces to offer a treatment program for alcohol addiction. The service is available to all alcoholics, both chest clinic patients and nonchest clinic patients. Patients are treated with Antabuse and ingroup meetings.

Antabuse for tuberculosis patients is now available at the chest clinics after a physical examination by Meyer W. Jacobson, MD, Clinical Director for Tuberculosis. The examination can be arranged through the City Chest Clinics given below or the Alcoholism Center, telephone 752-2000, extension 2756.

Group meetings for alcoholics are held at City Health Department clinics as follows:

Eastern Health District Building  
620 N. Caroline Street—Tuesdays—10:00 AM

Druid Health Center

1515 W. North Ave.—Wednesdays—10:30 AM

Western Health District Building

700 W. Lombard St.—Thursdays—10:00 AM

Southern Health District Building

1211 Wall Street—Fridays—10:00 AM

The sessions are conducted jointly by Mrs. Mary Tillery, Health Aide Alcoholism Counselor, and Mrs. Grace C. Gunts, Medical Social Worker, both of the Division of Tuberculosis and an Alcoholism Counselor of the Alcoholism Center. Physicians interested in discussing or referring cases for counseling may call A. M. Schneidmuhl, MD, MPH, at the Alcoholism Center located at 2221 St. Paul Street in Baltimore.



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*John Galsworthy*

FREDERICK J. BALSAM, MD, EDITOR

## **rehabilitation medicine**

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# **Rehabilitation And Acute Myocardial Infarction**

**B. STANLEY COHEN, MD**

Chief, Department of Rehabilitation Medicine  
Sinai Hospital of Baltimore, Inc.

**ALBERT GRANT, MD**

Associate, Department of Rehabilitation Medicine  
Sinai Hospital of Baltimore, Inc.

Exercise programs for patients with acute myocardial infarction are not new. The adverse effects of prolonged bed rest for such patients, as for all persons, have been well known for many years. These include deconditioning, with development of muscle weakness and atrophy, negative nitrogen and calcium balance, and alterations in peripheral vascular mechanisms. Loss of vasomotor tone diminishes tolerance to later assumption of the upright position, with distressing symptoms of weakness and dizziness, and possibly more serious vascular events.<sup>1-3</sup>

T. R. Harrison, in 1944, cautioned against the abuse of bed rest in cardiovascular disease.<sup>4</sup> At that time, following acute infarction, hospitalization of six weeks or more was the norm, and strict bed rest was enforced for at least four weeks of this period. In 1952, Levine and Lown<sup>5</sup> reported on the armchair treatment of myocardial infarction. Eighty-nine consecutive patients with acute myocardial infarction were treated shortly after admission to the hospital by sitting them next to their beds in a comfortable armchair. Despite this apparent radical departure from usual treatment of such patients, his mortality figures were quite favorable. In 1952, Newman reported an activity program for some 300 patients suffering from acute myocardial infarction.<sup>6</sup> He reported improved vasomotor stability and more rapid recovery of strength and endurance. In particular, anxiety was less evident and there was more satisfactory recovery and adjustment. His program began during the second week of hospitalization and progressed cautiously. Ambulation was begun in the fourth week.

With the passage of time, other programs were

described, with variations in time of onset, intensity, and rapidity of progression. All were based, however, on the premise that the prescription of exercise requires the same understanding of normal and pathologic physiology as the use of pharmacologic agents, and that dosage can be controlled, similarly, for desired results and avoidance of complications.

Graded activity programs were subsequently described by Kornbluch and Michels<sup>7</sup> and by Cain<sup>8</sup> and associates. The latter employed electrocardiographic monitoring during activity, which began 15 days post-infarction. By 1964, effectiveness had been demonstrated for programs beginning as early as three days following acute infarction.<sup>9</sup>

Application of the team approach to the management of the cardiac patient has drawn upon experience gained in dealing with other rehabilitation problems, with goals of physical, psychological, social and vocational rehabilitation.<sup>10-11</sup> Such programs have incorporated educational features and have been shown to be feasible in returning patients of all economic and social backgrounds to normal living and working levels.



An outline of the program which has been developed at Sinai Hospital of Baltimore follows. The program is a cooperative effort of the Department of Rehabilitation Medicine and the Department of Medicine—Division of Cardiology. This is a multidiscipline program to provide comprehensive services for the patient from the time of admission to the hospital to the date of discharge. It draws heavily on the program in effect at the Grady Memorial Hospital in Atlanta, under the direction of Nanette K. Wenger, MD. Included are medical evaluation and supervision, rehabilitation nursing, physical and occupational therapy, social and psychological services, vocational services, dietary counseling, and education for patient and family in dealing with his limitations.

All phases of the program involve cooperation among the attending physicians and the cardiology and rehabilitation physicians. The program involves two phases, the Acute (I) and Convalescent (II).

I—Acute: All patients in the Coronary Care Unit or acute patients in other areas of the hospital receive (a) passive range of motion to all extremities, (b) manual massage to the lower extremities, (c) girth measurements to the lower extremities, and (d) breathing exercises. Treatment and patient progress are recorded on the patients' charts daily. All patients in the Coronary Care Unit are monitored electronically during therapy and no treatment session is begun prior to conferring with the nurse in charge of that unit. Outside of the Coronary Care Unit, the patient is monitored by the treating therapist for any significant changes in blood pressure and pulse, and adverse symptoms during and at the conclusion of a treatment session. The acute phase in the Coronary Care Unit is four or five days, and the duration of each treatment is a maximum of 30 minutes.

II—Convalescence: This represents an extension of the acute phase, with increased activity as prescribed by the physician, exercises being matched to the permitted functional activity. The total program is a 12-step program as outlined below:

#### DEPARTMENT OF REHABILITATION MEDICINE CARDIAC REHABILITATION PROGRAM

Functional Activity	Educational and Planned Activity	Exercise
<b>Step 1.</b> Feed self while sitting with bed up to 45 degrees and arms supported. Bedside commode.	Initial interview and brief orientation to program.	Passive range of motion (R.O.M.) to all extremities. Massage to lower extremities. Girth measurements of lowers (once daily). Breathing exercises.

<b>Step 2.</b> Feeding self. Partial morning care (washing hands and face, brushing teeth) in bed. Dangle legs on side of bed (once).	Light recreational activity, such as reading.	Repeat exercises in Step 1.
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<b>Step 3.</b> Begin sitting in chair for short periods as tolerated (twice daily). Partial bath.	More detailed explanation of program. Light hand activity with arms supported in chair. Transfer with assistance.	Active assisted exercises in shoulder flexion and extension, hip flexion and extension, rotate feet (four times each).
--	---	--

<b>Step 4.</b> Increase sitting (three times daily).	Begin educational activities. Begin planned activities. Allow TV and radio.	Active exercise lying in bed doing above R.O.M. (five times each) stiffen all muscles to the count of 2 (three times).
---	---	--

<b>Step 5.</b> Sitting ad lib. Sitting in chair at bedside for meals. Dressing, shaving, combing hair, while sitting down. Walking in room (twice daily). Walk to bathroom for bowel movement.		Mild resistance in bed at 45 degrees in above R.O.M. exercises. Hands on shoulders with elbow circling (five times).
---	--	--

<b>Step 6.</b> Walk in bathroom, ad lib, if patient can tolerate. Stand at sink to shave.	Continue planned activity. Patient may attend group meetings in a wheelchair for no more than one hour.	Further resistive exercises sitting on side of bed, manual resistance of knee extension and flexion (seven times each movement). Walk distance to nearest bathroom and back (note if patient needs assistance).
--	---	---



<b>Step 7.</b> Bathe in tub or shower on seat.	May walk to group meetings on same floor.	Arms in extension and shoulder abducted, rotate arms together in circles (ten times). Stand on toes (ten times). Walk 50 feet and back to room at slow pace.
<b>Step 8.</b> Stay sitting up most of day.	Continue all previous educational and planned activities.	Lateral side bending (five times each side). Trunk twisting (five times each side). Walk 75 feet.
<b>Step 9.</b> Continue above activities. Walk to telephone. Walk to solarium.	Discussion of work simplification techniques and pacing of activities.	Lateral side bending (ten times) Slight knee bending with hands on hips (ten times). Increase walking distance.
<b>Step 10.</b> Continue all of previous functional activities.		Lateral side bending (ten times). Standing-leg raising (five times) and leaning against wall (ten times). Walk 100 feet and downstairs, take elevator up.
<b>Step 11.</b> Continue all previous functional activities.	Complete all projects.	Repeat all exercises in step above.
<b>Step 12.</b> Continue all previous functional activities.	Final instructions about home activity.	Lateral side bending (ten times). Trunk twisting (ten times). Touch toes from sitting position (five times). Walk up and down ten stairs.

The educational program is provided on an individual basis and in group sessions.

Hospital stay is generally 21-24 days and patients are generally ambulatory at discharge. Many have completed stair-climbing activities.

Phase I has been in effect since August 1, 1970, and has involved 461 patients. Phase II began February 1, 1971. To date, 129 patients have completed the program.

We have detected no adverse effects from the program. The treated patients have ranged in age from 23 to 86 years, including patients with arrhythmias, those who have required electrical defibrillation following cardiac standstill, and those recovering from congestive heart failure.

In addition to the goal of full restoration of function, the program is designed to minimize some of the complications of immobility such as venous thrombosis and embolism, atelectasis and pneumonia, shoulder-hand and musculoskeletally caused chest-pain syndromes. The effectiveness of early mobilization and exercises on reducing the incidence of such complications has been reported by a number of authors.<sup>12-14</sup>

A logical extension of such a program can include a third phase of planned progressive exercise on an outpatient basis, and a fourth phase with stress testing prior to a more intensive exercise program and return to work.

It has been emphasized that many patients can return to a life of work and recreational endeavors following recovery from acute myocardial infarction.<sup>15</sup> Supervised activity is desirable following convalescence. In addition, a change in daily habits may be in order, including alteration in dietary intake. It is in these areas that the educational facet of the program is of value.

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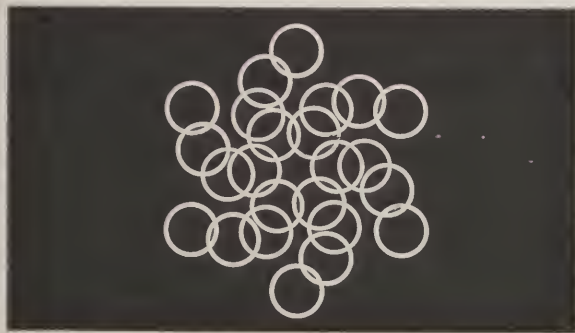
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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# Alcoholism: A Social Study on 200 Patients

**CLARENCE W. HURLEY, JR.**  
Alcoholism Counselor  
Mercy Hospital  
Baltimore

The purposes of gathering data on 200 patients suffering from alcoholism were to learn who was using the alcoholism counseling service at Mercy Hospital, to identify the target population of the service, and to determine the needs of those using the service.

A composite of the data indicated that the "average" patient is a white man, 30 to 59 years of age, unemployed and single, with no fixed address, and a grade school education or less. He is a chronic alcoholic and has a serious physical illness by the time he comes to the hospital.

The figures shown do not give a complete description and need further explanation. For example, the indigent alcoholics living within Mercy's area are predominantly white, and the addresses given were cheap hotels, rooming houses, dormitories, and temporary residences in homes of friends or relatives. The unemployment figure includes those receiving pensions of various kinds and social service checks for temporary disability. Those doing part time work or odd jobs were included in the unemployment figure. The high number of those with grade school education or less was surprising and may be explained, in part, by the number of middle-aged patients raised in small towns or farms in the South.

The most controversial finding is marital status—single. Many men said they were single, although later information revealed they were or had been married. It may be that denials of marriage were brought about by the shame, guilt, remorse, and rejection usually found in those with alcohol prob-

lems. Whatever the reason, the Mercy Hospital alcoholics are single at the time they apply for help, alone, without family ties of any kind.

The greatest single need of Mercy's alcoholics is housing. To meet this need, more half-way houses for recovering alcoholics are needed, as well as more shelters for alcoholics not yet in recovery. A foster home plan and boarding house facilities should also be considered. Other needs are for rehabilitation, job placement, and financial assistance, but they cannot be met until the housing problem is solved.

Baltimore leads all other cities in its alcoholism programs, and Maryland's laws and programs serve as a model for the nation. We can all be proud of that, but there is still much to be done.

### Social Data on 200 Alcoholic Patients Served by Mercy Hospital

<b>1. SEX</b>			
Male	190		95.0%
Female	10		5.0%
<b>2. RACE</b>			
White	155		77.5%
Black	44		22.0%
Indian	1		0.5%

(Continued on next page)



### 3. ADDRESS

Given	121	60.5%
None given	79	39.5%

### 4. EMPLOYMENT

Employed	28	14.0%
Not employed	168	84.0%
Student	1	0.5%
Unknown	3	1.5%

### 5. AGE

Under 20	2	1.0%
20-29	11	5.5%
30-39	47	23.5%
40-49	65	32.5%
50-59	56	28.0%
60-69	13	6.5%
70-79	5	2.5%
Unknown	1	0.5%

### 6. EDUCATION

Grade school or less	166	83.0%
Others	30	15.0%
Student	1	0.5%
Unknown	3	1.5%

### 7. MARITAL STATUS

Single	123	61.5%
Separated	20	10.0%
Divorced	17	8.5%
Married	31	15.5%
Widowed	7	3.5%
Unknown	2	1.0%

### REFERRALS FROM HOSPITAL DEPARTMENTS:

Emergency department	43	21.5%
Inpatients	98	49.0%
Outpatients	21	10.5%
Others	38	19.0%

### Other referral sources:

Court counselor—9
Rehabilitation counselor—3
Alcoholics Anonymous—5
Clergy and religious institutions—8
Local bar—11
Article in <i>Catholic Review</i> —16
Parole and probation officers—3
Prisoners aid—2

### REFERRED FROM COUNSELOR TO:

Alcoholism center—45
Alcoholics Anonymous—23
State hospitals (28)

Crownsville—22
Spring Grove—4
Springfield—2

(There have been no referrals to a state hospital in 1971)

Halfway houses—26
Tuerk Quarterway House—1
East End Hotel—Shelter—1
Missions—14
Nursing homes—4
University Hospital—6
Church Home and Hospital—1
Deceased—7



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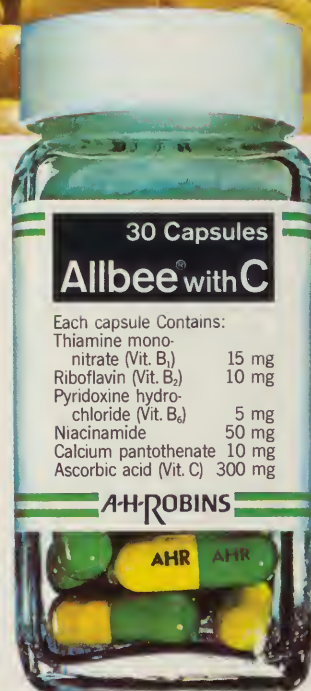
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MORRIS N. KOTLER, MD, EDITOR

*A Service of the Heart Association of Maryland*

## the heart page

# Mechanism Of Action Of Thyroid Hormone On The Heart

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The striking cardiovascular manifestations of thyrotoxicosis have attracted the attention of clinicians and researchers for many years. It was originally assumed that the hypermetabolic state and the need to dissipate excessive heat would induce generalized peripheral vasodilation with subsequent increase in circulatory velocity and cardiac output.<sup>1</sup> However, other features of the toxic patient such as the high incidence of arrhythmias due to increased automaticity, excitability, and the increased myocardial contractility, suggested that a direct cardiac stimulating mechanism was probably playing some role. A relationship between thyroid hormone and catecholamines was suspected,<sup>2</sup> and despite the great deal of information provided by clinical and experimental research, the intimate mechanism of such a relationship remains controversial.

The basic biochemistry of the cardiac muscle is schematized in Figure 1. Liberation of energy is achieved by the breakdown of glucose, fatty acids, pyruvate, and lactate providing the substrate to enter into the oxidative process of the Krebs' cycle. The free energy released is transferred by hydrogen electrons along the chain of mitochondrial enzymes, and not used directly for the contractile process. However, it is used in the formation of high energy

compounds, mainly ATP and CP (creatine phosphate), which will be stored for further use.

Glucose may also enter the pentose shunt pathway with formation of TPNH, or be converted to glycogen which represents a source of readily utilizable energy in case of hypoxia. The energy necessary for the contractile events is supplied by ATP. The concentration of glycogen in the cardiac muscle is kept at a very constant level of approximately 0.5% and, as proved by isotopic studies, does not represent an inert storage but a very active exchangeable pool. The enzymes that regulate this equilibrium are glycogen-synthetase for synthesis of glycogen and phosphorylase for its breakdown. This dynamic equilibrium can be affected by various factors; among them, catecholamines seem to play a major role.

It has been recently demonstrated that epinephrine and norepinephrine do not have a direct stimulatory effect on the phosphorylase, but its action is mediated by an enzyme-bound cofactor with phosphate groups in its structure located at the membrane level: adeny-

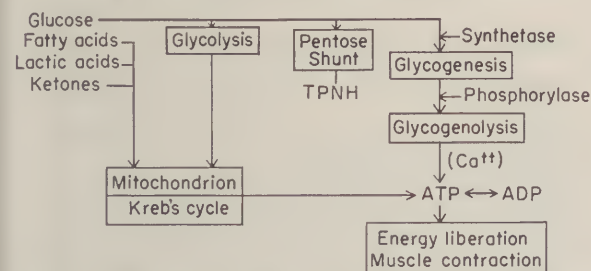
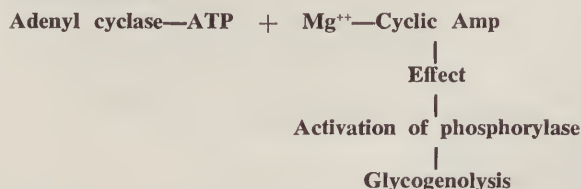


Figure 1: Metabolic pathway of energy sources involved in cardiac muscle contraction.



cyclase.<sup>3-5</sup> This enzyme has a catalytic effect on the cyclization of ATP to 3'-5' AMP, which acting as the "second messenger" will bring about the final effect.

#### Catecholamines



Recent evidence seems to identify the cardiac B-receptors with adenyl cyclase. Stimulation of the B-cardiac receptors results in: 1. Increased rate and, frequently, supraventricular tachyarrhythmias; 2. Increased conduction velocity at the A-V node and shortening of the refractory period; 3. Increased strength of muscle contraction and oxygen consumption; and 4. Glycogenolysis, and depletion of cardiac glycogen stores.

These effects can be abolished by previous administration of a B-blocker which probably competes with catecholamines at the receptor site. The similarity of adrenergic stimulation and the hyperdynamic circulatory state of hyperthyroidism has been revived by recent reports of favorable response of thyrotoxic patients to propranolol. Decreased heart rate, control of arrhythmias,<sup>6-7</sup> reduction of oxygen consumption, increase in Achilles reflex time, and weight gain<sup>8</sup> can be obtained without altering the level of circulating thyroid hormone.

Thus, several possibilities are worth considering in the thyrotoxic patient:

1. **Level of cardiac catecholamines:** Although there have been reports of both increased and decreased cardiac catecholamines in the thyrotoxic patient,<sup>8</sup> more recent experiments performed by Buccino<sup>9</sup> and co-workers seem to indicate no appreciable differences in the catecholamine content of the myocardium of hyperthyroid, hypothyroid, and normal controls.
2. **Level of urinary and plasma catecholamines:** The urinary excretion of catecholamines seems to be normal in patients with hyperthyroidism;<sup>10</sup> however, recent reports have shown that the urinary epinephrine-norepinephrine ratio is elevated.<sup>11</sup> Regarding the plasma level, there seems to be some controversy with several conflicting reports. The introduction by Engelman and Portnoy of a very sensitive double-isotope derivative assay for determination of norepinephrine and epinephrine<sup>12-13</sup> may shed some light on this problem.
3. **Sensitivity of the cardiac B-receptors to catecholamines on the face of supranormal levels of**

**thyroid hormones.** Similar increases in cardiac adenyl cyclase activity have been found in hyperthyroid and euthyroid animals after progressive doses of epinephrine.<sup>14-15</sup> Levey, Skelton, and Epstein, in a very elegant experiment, found no alteration in the sensitivity of papillary muscle of hyperthyroid and hypothyroid cats to similar doses of epinephrine.<sup>16</sup> Thus, there seems to be no evidence of increased sensitivity to catecholamines of the thyrotoxic heart, as measured by contractility and cyclic AMP production.

4. **Direct stimulating effect of thyroid hormone on B-cardiac receptors.** Levey and co-workers have found an increased cardiac adenyl cyclase activity after addition of T<sub>4</sub> and T<sub>3</sub>,<sup>17</sup> as measured by the conversion of AT<sub>32</sub>P to cyclic AMP. Interestingly enough, B-blockade with propranolol abolished the norepinephrine-induced activation of adenyl cyclase, but did not inhibit the effects of T<sub>3</sub> and T<sub>4</sub>. An additive effect was observed when both norepinephrine and thyroid hormone were incubated together.

Therefore, one may conclude that: 1. T<sub>3</sub> and T<sub>4</sub> have a direct stimulatory effect on myocardial adenyl cyclase in vitro. (Iodoproteins without metabolic activity were not found to have any stimulatory effect.) 2. The effect of thyroid hormone is not blocked by propranolol; therefore, it does not seem to be mediated by the same B-adrenergic receptor. 3. The additive effect also suggests that there are probably two different adenyl cyclase systems.

In summary, the intimate mechanism of action of thyroid hormone at the cellular level is not known as yet. Adrenergic stimulation plays a significant role on the circulatory status of hyperthyroidism, as judged by the effect of B-blockade. Thyroid hormone has also a direct action on the heart on a different adrenergic receptor site. Increased sensitivity of the catecholamine-responsive B-receptors in thyrotoxicosis does not seem to exist. Determinations of plasma and cardiac catecholamines awaits further research.

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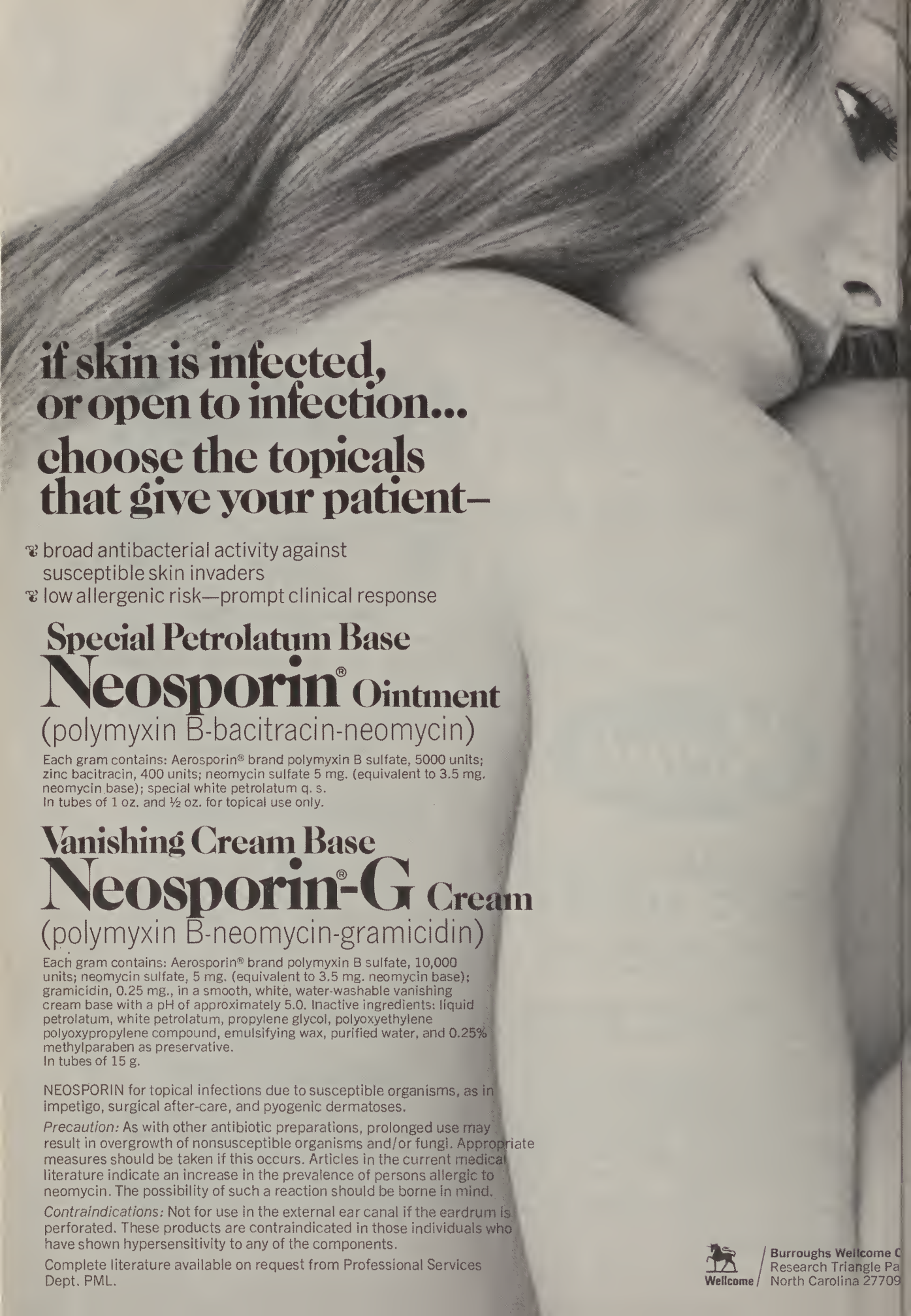
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## library

# Useful References in Medical Library Literature

In scanning the latest issue of the *Bulletin of the Medical Library Association* (July 1971) several titles caught my attention. A sampling of these includes:

*An investigation of the educational needs of health sciences library manpower: Part V: Manpower for hospital libraries.* By David A. Kronick, Alan M. Rees, and Leslibeth Rothenberg.

*Epilepsy abstracts retrieval system (EARS): A new concept for medical literature storage and retrieval.* By Roger J. Porter, et al.

*Publications on a drug before the first administration to man.* By Donald A. Windsor. ("The early published literature on thirty drugs used clinically in humans was searched and ranked chronologically for each drug.")

*The library from the nursing educator's point of view,* by Eleanor Waltes Treece. (Discusses utilization of nursing school libraries and suggests ways of assisting nurse educators and students toward better use of their libraries.)

*Bibliotherapy in a patients' library.* By David J. McDowell. (The author writes interestingly about his program with the patients' library at McLean Hospital in Belmont, Massachusetts. Often medical librarians in hospitals avoid any contact with the patients' libraries. This article would be helpful to any librarian of a similar library, particularly since many patients' libraries are operated by volunteer personnel.)

*Fifty years of the Index to dental literature: a critical appraisal.* By Malvin E. Ring.

*The evaluation of published indexes and abstract journals: criteria and possible procedures.* By F. W. Lancaster.

*A dirty mind never sleeps* and other comments on the oral history movement. By Peter D. Olch.—If

you are curious enough, you will look up this one!

AND, do you read **International notes** and **Book reviews**?

### Two Booklists Revised

In the April 1971 issue of the *Bulletin of the Medical Library Association* the fourth revision of the **Brandon Selected list of books and journals for the small medical library** appeared.

This is a well arranged, easily used list giving books by subject and author; journals by subject and title (alphabetically). Recommendations for first purchase are indicated by asterisk. Also included is a good list of 'References' consulted, which would be helpful to all.

Another list appeared in *New England Journal of Medicine*, December 31, 1970—**An integrated health-science core library for physicians, nurses and allied health practitioners in community hospitals**, by Norman S. Stearns, MD, and Wendy W. Ratcliff. This also has been updated and revised.

\* \* \*

The library regrets that there was no library exhibit possible at the semiannual meeting. So why not visit the library to see the new books and journals available?

### Forthcoming Meetings

Special Libraries Association, Baltimore Chapter—October 12, 1971. Subject: Copyright. Dinner Meeting. Place and speaker(s) to be announced.

Baltimore Hospital Librarians Association, September 23, 1971. Kennedy Institute, Baltimore, 2 PM.

Washington, D.C. Area Medical Library Association meeting, October 15-16, 1971, Winston-Salem, North Carolina. Host: Bowman Gray School of Medicine Library.



## NEW ACCESSIONS—BOOKS (Arranged by Subjects)

### ANATOMY

Healey, John E.

**A synopsis of clinical anatomy.** By John E. Healey, Jr., in collaboration with William D. Seybold. Philadelphia, Saunders, 1969. QS 4 H4 1969

### COMMUNICABLE AND VIRAL DISEASES

Debré, Robert

**Clinical virology;** the evaluation and management of human viral infections. Edited by Robert Debré and Josette Celers. With 58 international authorities. Philadelphia, Saunders, 1970. WC 500 D4 1970

U.S. National Communicable Disease Center, Atlanta.

**The project years:** tuberculosis program reports, December 1970 edition. Atlanta, U.S. Public Health Service, 1970. WF 200 U6 1970

### DIRECTORIES

Gale Research Company

**Encyclopedia of associations.** Edited by Frederick G. Ruffner, Jr., and others. Detroit, 1971. Ref. HS 17 G3 1971

Maryland Hospital Association, Inc.

**Directory of Maryland hospitals.** Baltimore, 1971. Ref. WX 22 M3

### DRUGS

American Medical Association. Division of Health Service.

**Directory of national voluntary health organizations.** 1968 ed. Chicago, 1968. Ref. W 22 .AA1 A5 1968

American Medical Association. Committee on Continuing Professional Education Programs of Voluntary Health Agencies.

**Continuing professional education programs of voluntary health agencies.** Chicago, 1967. Ref. W 22 .AA1 A5 1968

Pharmaceutical Manufacturers Association

**Brands, generics, prices and quality;** the prescribing debate after a decade. Washington, 1971. QV 748 P4 1971

Shader, Richard I.

**Psychotropic drug side effects;** clinical and theoretical perspectives. By Richard I. Shader, Alberto Di Mascio and Associates. Baltimore, Williams and Wilkins, 1970. QV 77 S4 1970

### EDUCATION AND RESEARCH

American Medical Association

**Medical education in the United States.** Chicago, 1970. Ref. R 745 M4 1970

National Conference on Health Education of the Public. 2d. Chicago, 1966.

**Proceedings.** Chicago, American Medical Association, Division of Socio-Economic Activities, Department of Health Education, 1967. WA 590 N3 1966

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U.S. Congress, 90th Senate. Committee on Government operations.

**Research in the service of man:** biomedical knowledge development and use. A conference sponsored by the Subcommittee on Government Research and the Frontiers of Science Foundation of Oklahoma, held at the Skirvin Hotel, Oklahoma City, October 24-27, 1966. W 20.5 U6 1967

U.S. Department of Health Education and Welfare.

**Public Health Service grants and awards.** Part 1, 1970. WA 20.5 P8 1970

### HEALTH

American Medical Association

**Medical-health film library.** Chicago, 1966. W 18 A5 1966

California Student Health Project.

**California Student Health Project, summer 1968.** Department of Pediatrics, Los Angeles County-University of Southern California Medical Center. Bethesda, Md., Health Services and Mental Health Administration, 1969. WA 546 .AC2 C2 1968

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**Chicago Student Health Project, summer 1968.** Bethesda, Health Services and Mental Health Administration, 1970. WA 546 .A13 C4 1968

Colorado Student Health Project.

**Colorado Student Health Project, summer 1968.** Bethesda, Health Services and Mental Health Administration, 1970. WA 546 .AC6 C6 1968

Greater New York Student Health Project.

**The Student Health Project of Greater New York, summer 1968.** Bethesda, Health Services and Mental Health Administration, 1969. W 546 .AC6 C6 1968

McNerney, Walter J.

**Health care reforms—the myths and realities.** American Public Health Association, 1971. WA 9 B7 1970

Philadelphia Student Health Project.

**Philadelphia Student Health Project, summer 1968.** Bethesda, Health Services and Mental Health Administration, 1969. WA 546 .AP4 P4 1968

U.S. Congress. Senate. Committee on Government Operations. Subcommittee on Executive Reorganization and Government Research.

**Federal role in health.** Washington, GPO, 1970. WA 525 U6 1970

U.S. National Institutes of Health

**The clinical center;** current clinical studies and patient referral procedures. Bethesda, U.S. Department of Health, Education and Welfare, 1970. Ref. W 20.5 U6 1970

Williams, Greer

**Kaiser-Permanente health plan;** why it works. Oakland, Calif., The Henry J. Kaiser Foundation, 1971. W 125 W5 1971

### HISTORY OF MEDICINE

American Medical Association. Council on Medical Education and Hospitals.

**The story of America's medical schools.** Chicago. History WZ 70 .AA1 A5

Baltimore. University. School of Medicine.

**Annual announcement and catalogue.** Baltimore, Guggenheim, Weil & Co., 1886-87, 1896-97, 1900-1901, 1902-1903. History W 19 B2

Lining, John

**The Static Experiments of Dr. John Lining, 1740,** Charleston, South Carolina. Reprinted by the South Carolina Medical Association, 1970. History Cfc

### MEDICAL FACILITIES—PLANNING

American Surgical Trade Association

**ASTA guide for physicians office planning.** 1969. W 80 A7 1969



Maryland Surgical Supply

**Hospital equipment and supplies.** Surgical Catalog Co., 1969. Ref. W 26 M3 1969

U.S. Public Health Service. Division of Hospital and Medical Facilities.

**Proceedings: 1966 Conference of Hill-Burton and Mental Retardation authorities with the Surgeon General.** Silver Spring, U.S. Public Health Service, 1967. WX 140 U6 1966

#### MENTAL ILLNESS

Massachusetts. Commission on Lunacy, 1854.

**Insanity and idiocy in Massachusetts: report of the Commission on Lunacy, 1855.** By Edward Jarvis. Cambridge, Harvard University Press, 1971. History WM 100 M3 1971

President's Task Force on the Mentally Handicapped. **Action against mental disability.** Washington, GPO, 1970. WM 100 P7 1970

#### OBSTETRICS AND GYNECOLOGY

Greenblatt, Robert Benjamin

**Progress in conception control; the sequential regimen; second physicians conference.** Philadelphia, Lippincott, 1966. QV 177 G7 1966

Maryland State Department of Health and Mental Hygiene. Bureau of Preventive Medical Services.

**Regularly scheduled maternal health and family planning clinics in the counties of Maryland.** Baltimore, 1971. Ref. WP 630 M3

Odell, William D.

**Physiology of reproduction.** By William D. Odell and Dean L. Moyer. St. Louis, Mosby, 1971. QP 251 02 1971

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International Symposium on Asthma and Chronic Bronchitis in Children and Their Prognosis into Adult Life. 3d. Davos (Switzerland) 1969.

**Third international Symposium on asthma and chronic bronchitis in children and their prognosis into adult life.** Davos, October 23-24, 1969. Edited by F. Suter. N.Y., Karger, 1969. WF 553 I6 1969

U.S. National Institute of Child Health and Human Development.

**Child health and human development: progress 1963 1970.** Scientific editors: Frank Falkner and Georgia Perkins Reaser. Washington, GPO, 1970. WS 103 U6 1970

#### PRACTICE OF MEDICINE

American Medical Association. Department of Insurance and Practice Management.

**Peer review manual.** Chicago, American Medical Association, 1971. Ref. W 21 A5 1971

Howe, Henry F.

**The physician's career; teaching outline on medical practice and community relations for physicians and medical students.** Chicago, American Medical Association, 1967. W 18 H6 1967

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Gillespie, J. A.

**Modern trends in vascular surgery. I.** New York, Appleton-Century-Crofts, 1970. (Modern Trends Series). WG 168 G5 1970

Kerr, J. A.

**Appendicitis: the seven anomalies.** London, Butterworth, 1970. WI 535 K4 1970

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**The hand.** From 5th ed. of Campbell's Operative orthopaedics. Edited by A. H. Crenshaw. St. Louis, Mosby, 1971. WE 830 M5 1971

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Roen, Philip R.

**Atlas of urologic surgery.** Illustrated by Charles Stern. New York, Appleton-Century-Crofts, 1967. WJ 17 R6 1967

**Year Book of Urology, 1971.** Chicago, Yearbook Medical Publishers. WJ 100 Y4 1971

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**Background studies prepared by state committee for the White House Conference on Aging.** Washington, GPO, 1960. WT 30 U6 1960

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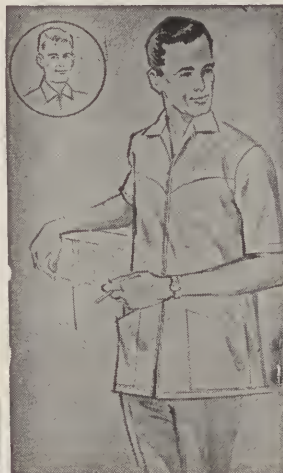
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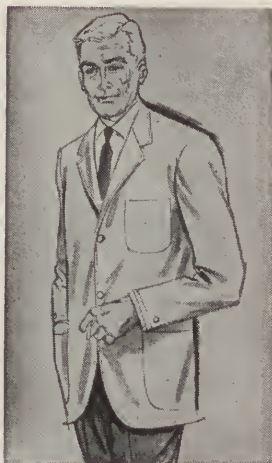


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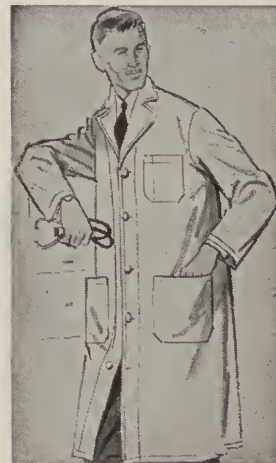
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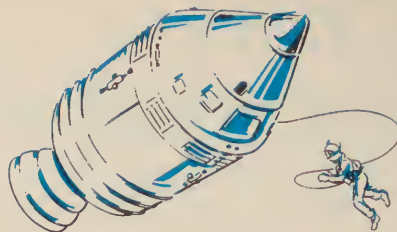
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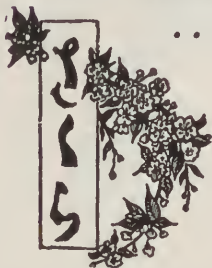
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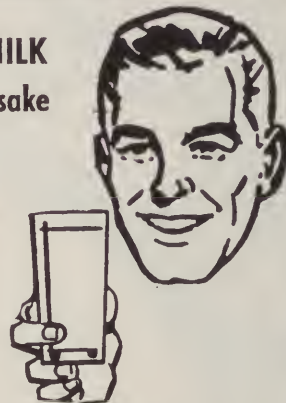
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## 1970: A Good Year For Life

One of the better years for life! That's how 1970 was viewed by the statisticians of Metropolitan Life Insurance Company who report that the mortality rate in the United States was slightly lower in 1970 than in 1969. They estimate the 1970 national death rate at about 9.4 per 1,000 population compared with 9.5 in 1969. This represents the 23rd consecutive year in which a death rate below 10 per 1,000 population was registered in this country.

Infant mortality, which recorded a low of 21 per 1,000 live births in 1969, probably showed another low in 1970. Infant mortality, for the first time in this country, dropped to less than 20 per 1,000 live births in 1970 and the infant mortality rate in the U. S. showed nearly a 25% decline from 1960 to 1970, compared with a decline of only 11% from 1950 to 1960.

Diseases of the heart, which are currently responsible for nearly two fifths of all deaths in this country, showed a slightly lower mortality rate in 1970 than in 1969. The rate for the ischemic type of heart disease, mainly coronary heart disease, decreased from a year ago by about 1.5%. No signifi-

cant change in the mortality rate from cerebral vascular disease was noted, according to the statisticians.

Cancer, which runs second to heart disease as a cause of death, continued its gradual uptrend, showing a mortality rise of approximately 2% in 1970 from the year earlier. This small rise likely reflects an increase in the death rate from cancer of the respiratory system.

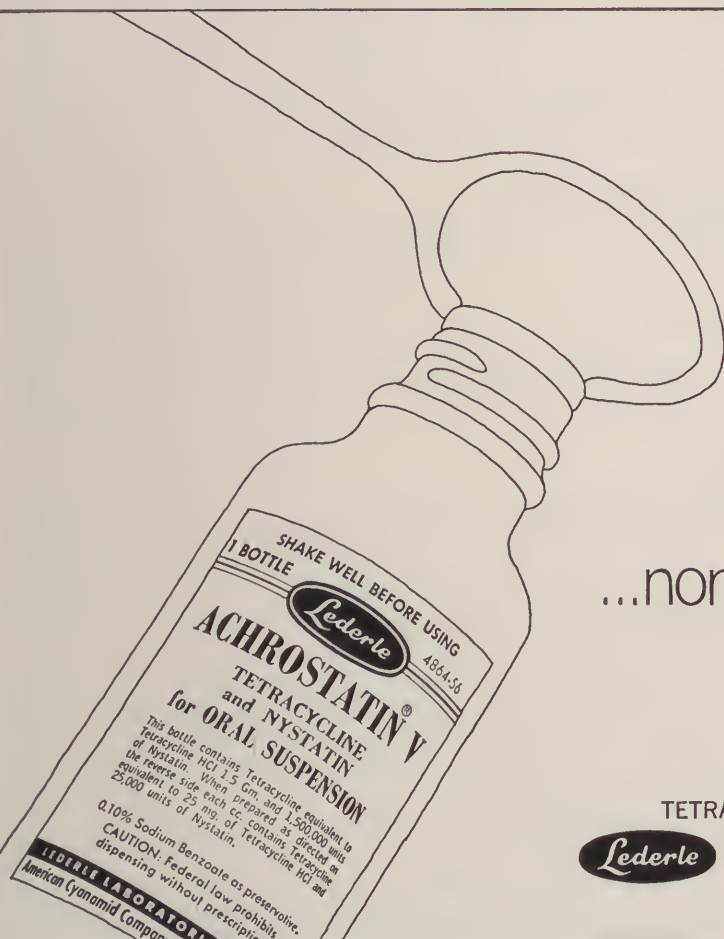
Diabetes mortality showed a slight increase in 1970 while the death rate from cirrhosis of the liver was up by 6%.

There was a sizable decline in the mortality rate from influenza and pneumonia (a figure which often varies materially from year to year). A mortality rate of about 30 per 100,000 was estimated for 1970—about 15% below that in 1969. The decline represents a return to more usual levels from the high influenza death rates which prevailed in early 1969.

Provisional data indicate that the number of motor vehicle accident fatalities in 1970 declined by about 2% from 1969. The death toll from all types of accidents combined was also lower than in 1969, according to Metropolitan Life.

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## a plan for living with hypertension



# Ser-Ap-Es®

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**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly. **Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

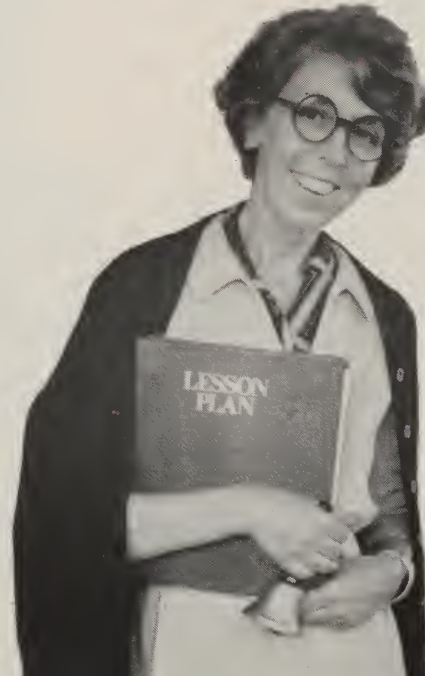
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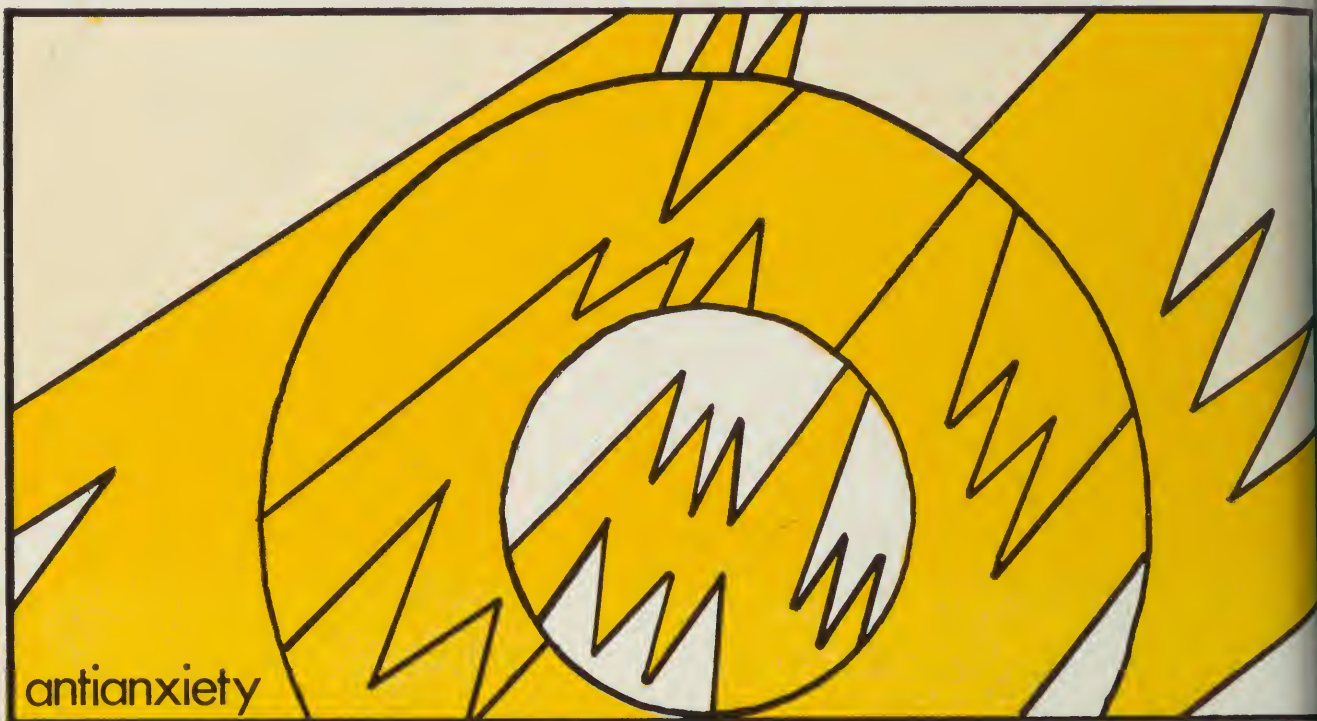
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Unless "defused," anxiety may build up to an intensity that can overwhelm the patient's inner defenses. Also, in one weakened by chronic illness or surgery, excessive anxiety may provoke or aggravate symptoms and interfere with recovery.

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for severe anxiety

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating ma-

chinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impend-

ing depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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# Patients fell asleep quickly

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Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

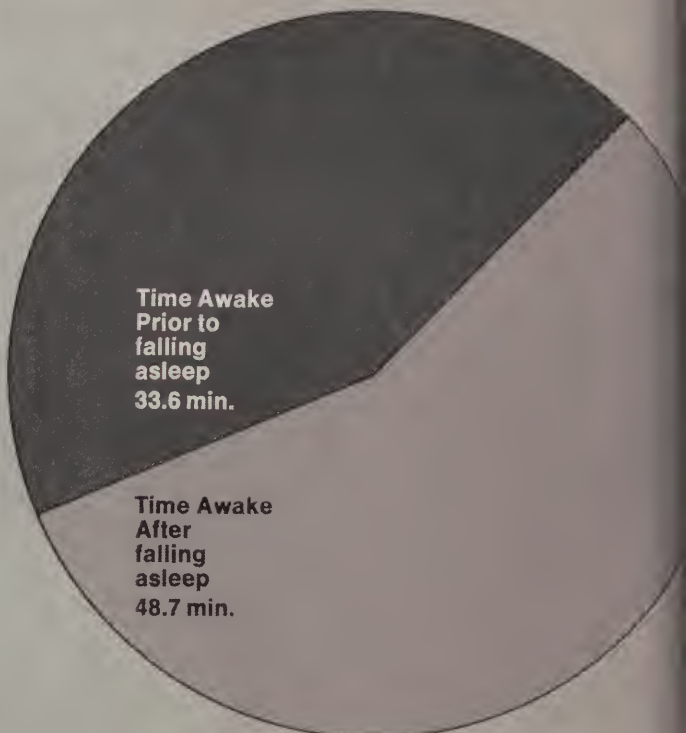
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

**References:** 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

Before  
Dalmane  
(flurazepam HCl)





# and slept through the night

On  
Dalmane  
(flurazepam HCl)

Time Awake  
Prior to  
falling  
asleep  
17.6 min.

Time Awake  
After  
falling  
asleep  
22.6 min.

Average sleep laboratory measurements in cited studies

Parameter	Before Dalmane	On Dalmane
Time required to fall asleep	33.6 min.	17.6 min.
Wake time after onset of sleep	48.7 min.	22.6 min.
Number of wakeful periods after onset of sleep	12.2	8.4
Total sleep time	420.0 min.	447.5 min.
Percent sleep percent	88.6	94.5

Clinical effectiveness as  
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elderly or debilitated patients.

**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use only in women who are or may become pregnant when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

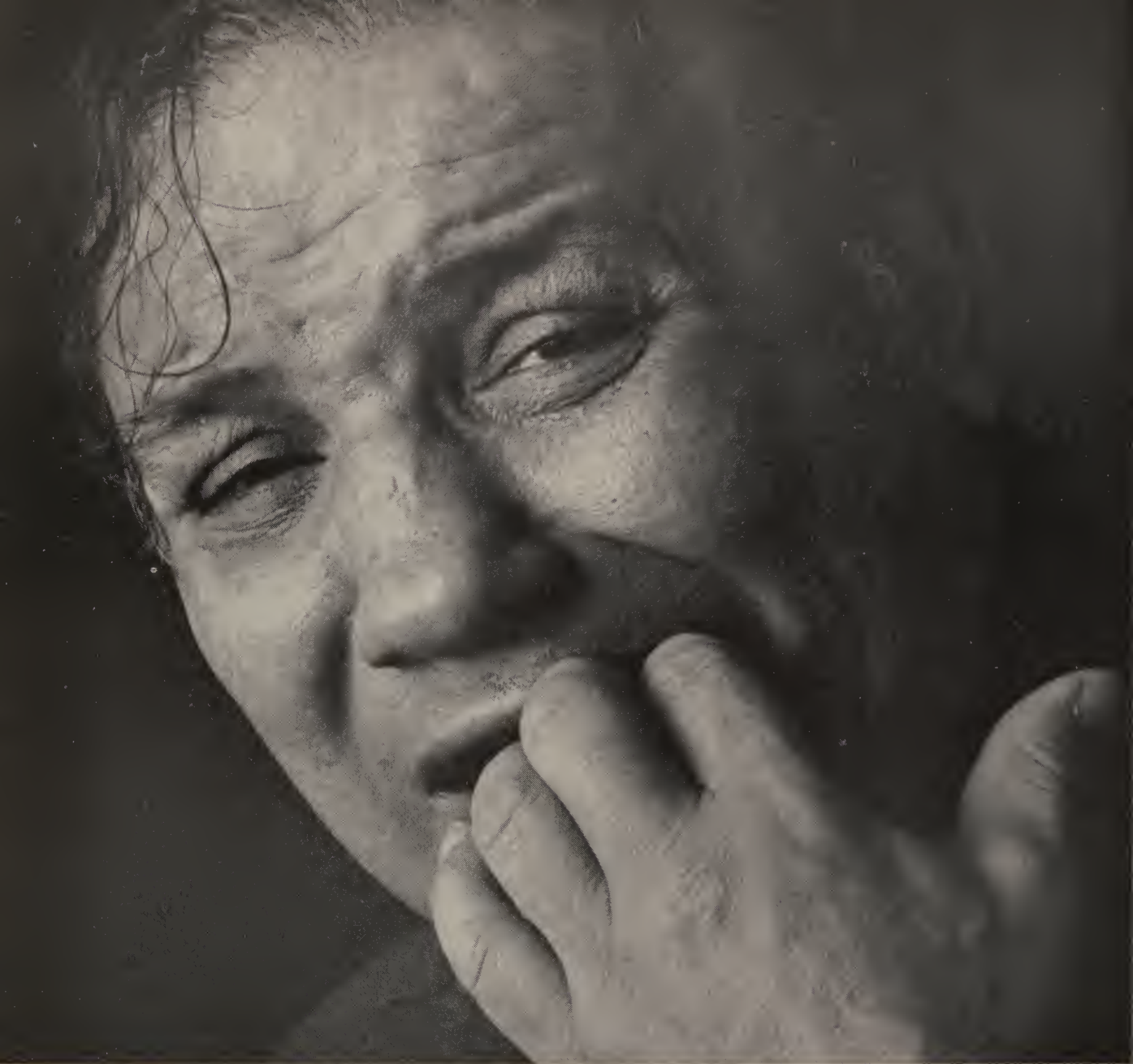
**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



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"Recent studies of the Baltimore Standard Metropolitan Statistical Area seem to indicate a declining urban population accompanied by a growing suburban population and decreasing numbers of urban-based, primary-care physicians over the past 40 years. What, then, is the current pattern of health care in this region and what is the present distribution of primary-care physician manpower?"

### A Psychiatric Syndrome in Women Evaluated for an Unwanted Pregnancy

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"A woman's desire for an abortion is her recognition that the pregnancy is the end result of a complex emotional conflict related to unsatisfactory relationships to men, her experience of intimacy in the family structure, her status on the dependency-interdependency axis, her self image, and her knowledge and anxiety about sexual physiology. Resolution of the conflict by psychotherapy is difficult."

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# Doctors take note...

## Maryland Meetings

- October 22-24 *Heart Assoc. of Md. Annual Meeting.* Hunt Valley Inn, Cockeysville.
- October 29-30 *Multidisciplinary Treatment of Alcoholism—The Changing Role of the Physician and Allied Health Professionals.* Sponsors: Univ. of Md. School of Medicine, Med-Chi, Div. of Alcoholism Control of Md. Dept. of Mental Hygiene, Baltimore City Dept. of Health Alcoholism Center, Baltimore Area Council of Alcoholism, and The Johns Hopkins Univ. School of Medicine. Place: Thos. B. Turner Auditorium, The Johns Hopkins Univ. School of Medicine, Baltimore.
- October 29-30 *American Cancer Society Annual Baltimore Area Conference.* Hunt Valley Inn, Cockeysville.
- November 19 *Progress in Pediatrics, 1971.* Sponsors: The Johns Hopkins Children's Medical & Surgical Center and the Md. Chapter, American Academy of Pediatrics. Contact: Matthew Debuskey, MD, CMSC 2-124, Johns Hopkins Hospital.

## American Academy of Facial Plastic & Reconstructive Surgery

- November 7-11 *Surgery of the Aging Face.* Dept. of Otolaryngology, Abraham Lincoln School of Medicine, Univ. of Illinois College of Medicine. Contact: M. Eugene Tardy, Jr., MD, Dept. of Otolaryngology, Univ. of Illinois, 1855 W. Taylor, Chicago, Ill. 60612.

## American College of Chest Physicians

- November 18-20 *Mayo Clinic Conference of Management of Respiratory Insufficiency.* Sponsors: Mayo Graduate School of Medicine, Univ. of Minnesota, and ACCP. Place: Rochester, Minn.
- December 3-5 *Chest Trauma—Recent Advances in Emergency Management.* Sponsors: ACCP, New York Univ. Bellevue Hosp. Center. Place: New York City.

## American College of Surgeons

- October 25-31 *Management of Common Fractures and Dislocations.* Cook County Graduate School of Medicine, Chicago, Ill. Contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, Ill. 60612.
- November 4-6 *AAOS Course in Emergency Care,* American Academy of Orthopaedic Surgeons, Johnson City, Tenn. Contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611.
- November 9-13 *AAOS Course for Emergency Room Nurses,* American Academy of Orthopaedic Surgeons, Dallas, Tex. Contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611.



### American College of Obstetricians and Gynecologists

- October 25-29 *Obstetric and Gynecologic Pathology*, Livingston, N. J. Contact: James L. Breen, MD, Director, Dept. of Obstetrics Gynecology, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, N. J. 07039.
- October 28-30 *Third Annual Pre-Board Review of Obstetrics and Gynecology*. Chicago, Ill. Contact: Mr. Neis H. Berg, Exec. Asst., Dept. of Ob-Gyn, Univ. of Chicago, Chicago Lying-in Hosp., 5841 S. Maryland Ave., Chicago, Ill. 60637.
- November 1- 5 *Recent Advances in Obstetrics & Gynecology*. New York City. Sponsor: Columbia Univ. College of Physicians & Surgeons. Contact: Melvin D. Yahr, MD, Assoc. Dean, College of Physicians & Surgeons, 630 W. 168th St., New York, N. Y. 10032.
- November 4- 5 *Birth Defects and Fetal Development—Endocrine and Metabolic Factors*. Detroit, Mich. Contact: K. S. Moghissi, MD, Dept. of Ob & Gyn, Wayne State Univ. School of Medicine, 432 E. Hancock, Detroit, Mich. 48201.

### American College of Physicians

- October 25-29 *Recent Progress in Clinical Cancer*. An interdisciplinary approach to cancer and its management. Memorial Sloan-Kettering Cancer Center, New York, N. Y.
- November 1- 5 *Respiratory Pathophysiology*. Designed to bridge the gap between respiratory physiology and clinical pulmonary medicine. McGill University Faculty of Medicine and Royal Victoria Hosp., Montreal, Quebec.
- November 3- 5 *Current Concepts of Clinical Infectious Diseases*. Devoted to management of common infectious problems and appraisal of advances in field of infectious disease and immunology. Univ. of Virginia School of Medicine, Charlottesville, Va.
- November 15-17 *Clinical Gastroenterology for the Internist*. Designed to interest all physicians who specialize in gastroenterology or have significant interest in this field. Dept. of Gastroenterology, Lahey Clinic Foundation, Boston, Mass.
- November 15-19 *Clinical Uses of Radionuclides*. Critical comparison with other techniques. Med-Division, Oak Ridge Associated Universities.
- November 17-19 *Solving Problems in Clinical Hematology*. Intended for clinical hematologists and internists with special interest in hematology. University of Alabama Medical Center, Birmingham, Ala.
- November 17-19 *Rehabilitation and the Internists*. Designed to familiarize internists with possibilities, procedures and problems involved in rehabilitation of patients with physical impairments. Mayo Clinic, Rochester, Minn.

For information on these ACP postgraduate courses contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

### Miscellaneous Meetings

- October 23 *AGA Regional Postgraduate Day*. Sponsors: American Gastroenterological Assoc., Penna. Academy of Gen. Practice, and Univ. of Pittsburgh School of Medicine. Place: Pittsburgh Hilton, Pittsburgh, Pa. Write: AGA Postgraduate Courses, Box 190, McLean, Va. 22101.
- October 28 *Seventh Annual Symposium on Air Pollution & Respiratory Disease*. Sponsor: N. Y. State Action for Clean Air Committee. Place: Downstate Medical Center, State Univ. of New York, Brooklyn.



- November 8 *Symposium on Exercise & the Heart*. Sponsors: AMA Comm. on Exercise & Physical Fitness, Pa. Med. Society, Pa. Heart Assoc., and the President's Council on Physical Fitness & Sports. Place: Host Farm Resort Motel, Lancaster, Pa. Contact: Dept. of Health Educ., AMA, 535 N. Dearborn St., Chicago, Ill. 60610.
- November 8-11 *Clinical Therapeutics, 1971—Emergency Medicine*. Sponsors: Pa. Medical Society and Pa. Nurses Assoc. Place: Host Farm Resort Motel, Lancaster, Pa.
- November 10-13 *Fifth Annual Postgraduate Conference on Today's Hospital Problems*. Sponsors: Mound Park Hosp. Foundation and College of Medicine, Univ. of South Florida. Place: St. Petersburg, Fla. Write: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.
- November 15-17 *Fifty-sixth Annual Scientific Assembly*. Sponsors: Arthritis Foundation and Interstate Postgraduate Medical Assoc. of North America. Write: Alton Ochsner, MD, P. O. Box 5445, Madison, Wisc. 53705.
- November 22-23 *Bioavailability Conference to Study Case Histories of Four Drugs*. Sponsor: U. S. Pharmacopeial Convention. Contact: Robert H. Henry, Director of Professional Affairs, U. S. Pharmacopeia, 12601 Twinbrook Parkway, Rockville, Md. 20852.

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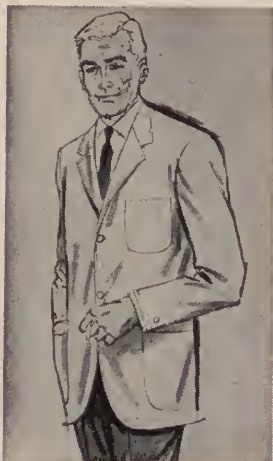
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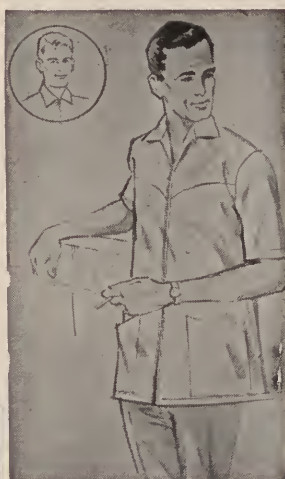


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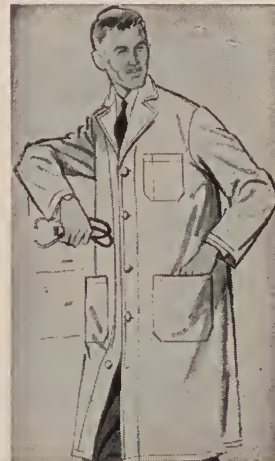
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# executive director's newsletter

October 1971

IPAC  
BOARD  
SESSION

A Board Meeting of the Maryland Medical Political Action Committee is planned for Thursday, October 28, at 6:30 PM. Invitations have been extended to Component Society Legislative Chairmen and their wives as well as to Component Auxiliary Chairmen and their husbands.

Reservations are required for cocktails and dinner and should be made through the Faculty office. Discussion will take place on How the PAC Movement Can Help in Medical and Health Care Legislation.

ANNUAL  
MEETING

The Faculty is co-sponsoring the annual meeting of the American Medical Society on Alcoholism set for Friday and Saturday, October 29 and 30, at the Turner Auditorium, Johns Hopkins Hospital.

All physicians are cordially invited to attend. Programs may be obtained by calling the Faculty office.

SEMIANNUAL  
ACTIVITY

Full details on actions of the Council and House of Delegates taken at the Semiannual business meeting, Saturday, September 11 can be found elsewhere in this Journal. All members are urged to peruse the many important decisions made at that time.

PHYSICIAN  
DIRECTION  
TO  
PHARMACIES

Physicians are reminded it is unethical to direct a patient to any particular pharmacy. On occasion, physicians have indicated that chain-store pharmacies are lower-priced than an independent pharmacy.

While this may be true in some cases, it is not always so.

The Code of Cooperation, agreed to between the two professions, emphasizes the right of the patient to have free choice of pharmacy and to select that pharmacy which will serve him best.

WITHOUT A FACULTY  
THIS MIGHT  
HAVE HAPPENED

Chiropractors would have been included under the Blue Shield program and classed with physicians and other professionals.

It would still be illegal for a physician to treat minors for venereal disease or pregnancy....a law that was



WITHOUT A FACULTY  
THIS MIGHT  
HAVE HAPPENED  
(cont'd)

amended last July 1 to an expansion of medical conditions for which minors could be treated.

The State Comprehensive Health Planning Agency would have authority to direct where a professional could practice and the field in which he could practice.

The control of physician licensing could pass to non-physicians together with determinations as to qualifications for practice, continuing education, etc.

All hospitals would have been required to grant privileges to all physicians who request them, regardless of training, capability, etc.

There would be no control over the unethical and illegal practitioner and no control (Peer Review) over the incompetent or unsatisfactory physician.

Effective liaison with other professions as well as state and local governmental agencies would not be at its present high standard.

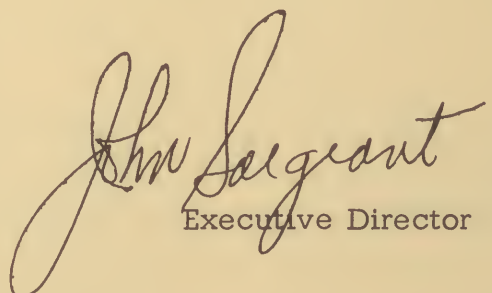
No effective mechanism would exist for study in depth of the current professional liability insurance crisis.

No reasonably priced insurance would be available in many fields.

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To those members of the Med-Chi retirement plan who made contributions in August 1971, the unit value of the fund was \$1.459. This reflects a 17% increase since December 1970, when the unit value was \$1.247. Participants are reminded to make their annual contributions before December 31st. Anyone interested in participating in the Keough Plan may call the Med-Chi Trust office at 539-0872.

  
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## Baltimore City Medical Society

### Board of Directors Meets

The Board of Directors met on August 10, 1971 at 4:30 PM in the Medical and Chirurgical Faculty building.

After the minutes of the July 13 meeting were approved, Philip Wagley, MD, reviewed a list of physicians' fees provided the State Health Department by the Medical and Chirurgical Faculty in February 1971. This was compiled from a survey conducted by the Faculty of 1,000 physicians throughout the state and was used by the health department in determining the fees to be paid for Medicaid recipients. It was the opinion of the Board that this survey was an inadequate basis for setting the fees and that a more extensive survey should have been done before the information was sent to the health department. A copy of the report is available from the BCMS office.

The Board was also informed that Hiroshi Nakazawa, MD, has accepted the chairmanship of a committee to study the details of the Braxton/Carter Associates and other group practices in the city and to publish its findings if appropriate.

The following standards for the use of oxytocics were approved by the Board. These were prepared by the Peer Review Committee and have been approved by the Maryland OB-GYN Society.

1. Oxytocics should not be used for stimulation or augmentation of labor outside a hospital.
2. Oxytocics should be used only in hospitals for recognized indications. Their use should conform to the rules established by the chief of service of the hospital.
3. The use of oxytocics for home delivery is not consistent with acceptable standards of obstetrical care. Their use to circumvent the

lack of obstetrical privileges is deemed totally indefensible.

4. Sparteine sulfate should not be used for the stimulation or augmentation of labor except in the hospital under the same restrictions as any other oxytocic.
5. Sparteine should not be used except under the control of a board certified or board qualified obstetrician under the same restrictions as any other oxytocic.

A motion to approve a retainer for Mr. William J. Evans, parliamentarian for the Society, was unanimously approved, and the Board expressed its appreciation to Mr. Evans for his help in the past.

The Board approved the purchase of reprints from the July 1971 issue of *Reader's Digest* of an article entitled "Should Chiropractors be Paid with Your Tax Dollars?" These copies will be sent to the membership reminding them that legislation allowing chiropractors to be paid under Medicaid was nearly enacted last year and that physicians must be prepared to fight this again in 1972.

A questionnaire was received from the AMA which requested information about off-hour elective and semi-elective care facilities in the Baltimore area other than hospital emergency rooms. A letter will be written stating that the Regional Planning Council is presently conducting a survey of emergency care facilities in the state of Maryland and there are presently several hospitals and group practices in the city which have established night clinics for nonemergency care.

Robert Gibson, MD, and David Danielson of the Maryland Health Maintenance Committee, Inc. addressed the Board concerning the activities of this group.



The Maryland Health Maintenance Committee has received a \$250,000 contract from the federal government to finance the first year's operation. The plan is to formulate a basic package of health care services for which a yearly premium will be charged. The purchasers of the package will receive medical care as described in the plan from various group practices which will be established throughout the city and which will have contracts with the committee. The largest single group of enrollees is expected to be union workers and it is expected that this will be used for a bargaining agent. The state will be able to purchase the plan for Medicaid recipients but no mechanism has been established for the purchase of the package by persons of marginal income.

The funds allocated by the federal government will be used primarily for staffing and planning, but it is expected that at least a portion of the plan will be in effect by February 1972.

In the discussion that followed the presentation, it was noted that lay representatives on the committee outnumber physicians by a ratio of three to one and that this is becoming the practice in the planning of health-care delivery systems.

The economic aspects of this type of program were discussed and it was stated that no profit would be expected for several years after the beginning of operations but that this was well known to the planners and costs were based on the expected loss for several years. It was agreed to invite Dr. Henry Seidel, director of the Columbia Plan, to the next meeting of the Board to discuss his experiences with a prepaid group program.

The Board approved the recommendation of the Bylaws Committee which would increase the membership dues in the society from \$25 to \$45. Dr. Wagley stated that dues for the Baltimore City Medical Society are well below those charged

by societies of comparable size and that if the society expects to keep pace with the changes in medicine, funds must be made available for increased activities and staff. This amendment will be presented at the October 7 meeting and acted upon at the November 4 meeting. The proposed amendment reads:

"Amend Article IV (Finance) Section 1 (a). by striking out \$25.00 and inserting '\$25.00 for the first two years after training or fellowship, or discharge from active duty in the armed forces; \$45.00 thereafter.'"

The Board was informed that the recipient of the society's scholarship, Andre W. Poe, has been accepted in The Johns Hopkins University premedical school.

Notification was received from the Maryland Commission on Medical Discipline of the revocation of the license to practice medicine of a Baltimore city physician. Revocation of license calls for automatic expulsion from membership in the society. The Board agreed that the physicians who endorse the application of a physician whose license is later revoked should be notified of the action. This is done in the hope of impressing upon the members the importance of sponsoring a physician for membership in the society.

The subject of unlicensed physicians providing patient care in hospitals was discussed. A survey performed by the Maryland Hospital Association and transmitted to the Board of Medical Examiners last year showed that 18 hospitals in the state of Maryland were using 71 physicians to provide patient care. After some discussion as to possible courses of action, it was decided to write a letter to the Board of Medical Examiners asking if any action has been taken on this report and to send copies of the letter to Baltimore city hospitals.

There being no further business, the meeting adjourned at 6 PM.

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MRS. WALLACE H. SADOWSKY, EDITOR

**woman's auxiliary**

## Maryland's Physicians and Wives Play Important Role In Supporting AMA-ERF

For the second consecutive year, the Montgomery County Medical Auxiliary received an award from the American Medical Association Education and Research Foundation for making the largest contribution to AMA-ERF in the past year of all county medical auxiliaries in the 101-200 membership category. The contributions of the Montgomery County Medical Society members, coupled with proceeds from Auxiliary-sponsored fund-raising projects, totaled \$5,909.97 for AMA-ERF. The presentation was made at the annual convention of the Woman's Auxiliary to the AMA in Atlantic City in June 1971.

According to Robert A. Enlow of the National AMA-ERF Foundation, "The Woman's Auxiliary this past year raised the largest amount in the 20-year history of their support of AMA-ERF." The "amount" Mr. Enlow referred to was \$550,927.01! Maryland's share in this record-breaking sum for the year July 1, 1970 through June 30, 1971 was \$21,978.66.

Maryland contributions by county for the period July 1, 1970 thru May 31, 1971 are as follows:

County	Faculty	Auxiliary	Total
Allegany	\$ 530.00	\$ 358.92	\$ 888.92
Baltimore city	5,610.00	748.59	6,358.59
Baltimore	1,200.00	342.73	1,542.73
Carroll	235.00	—	235.00
Cecil	250.00	171.10	421.10
Four-County	495.00	83.85	578.85
Harford	290.00	477.97	767.97
Montgomery	3,835.00	2,074.97	5,909.97
Prince George's	1,435.00	115.00	1,550.00
Washington	295.00	332.87	627.87
Wicomico	395.00	437.98	832.98
Members-At-Large	1,555.00	308.68	1,863.68
State		208.00	208.00
<b>TOTALS</b>	<b>\$16,125.00</b>	<b>\$ 5,660.66</b>	<b>\$21,785.66</b>

The fastest growing crisis in fund-raising for AMA-ERF is the plight of the medical schools. The crying need for better and larger facilities,

additional and more modern equipment, and more faculty members will require an astronomical amount of money.

AMA-ERF funds provide flexible financial aid for the deans of medical schools to use in solving their most pressing financial problems. It is reported "... even schools with large endowment programs are facing financial belt-tightening because their funds are often earmarked for special projects."

John M. Moxley III, MD, Dean of the University of Maryland School of Medicine, in a letter dated July 30, 1971 expressing appreciation for funds received through AMA-ERF, wrote: "Your thoughtful gift through the American Medical Association Education and Research Foundation will help to provide the School with the flexible funds necessary to pursue our many activities.

"Support we receive from the state is earmarked for specific purposes and comes to us a year after we initially request it. It is vital, therefore, that we continue to receive gifts from alumni and friends in order to keep our various educational programs current and stimulating."

(Note: Funds cannot be accepted for specific departments, individuals, buildings, etc—only for the medical schools to use as they choose.)

Currently, there are 113 United States and Commonwealth and 16 established Canadian medical colleges that will receive all designated funds sent to AMA-ERF. Only 103 certified United States medical colleges currently share in undesignated funds. (A list of eligible medical schools will be provided by the state AMA-ERF chairman upon request.)

The AMA-ERF Foundation released a lengthy statistical report dated March 3, 1971 concerning





Mrs. Raymond M. Yow, immediate past-president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, accepts the certificate of County Achievement Award on behalf of the Woman's Auxiliary to the Montgomery County Medical Society. The award was presented at the AMA Auxiliary Convention in Atlantic City in June 1971.

the Loan Guarantee program. Over an eight-year period (March 1962 through December 1970), 615 Marylanders received loans under this program, amounting to \$736,228. AMA-ERF loans were made to 51 Marylanders during the period January 1970 through December 1970, totaling \$63,938.

Although the federal government is already pouring millions of dollars into the area of loans for students, federal funds are not limitless. The Department of Health, Education and Welfare reports that only some of our medical students can receive federal aid and that additional help must come from private sources.

The AMA-ERF Loan Guarantee program is as comprehensive as the government's, and perhaps more so, in that it includes hospital interns and residents as well as medical students. Perhaps because they are trying to support a family and are possibly repaying other loans, it would be reasonable to assume that many of these young physicians need money even more than students.

The AMA-ERF Foundation reports, "Contrary to general belief, the average medical student is not rich. From a study completed recently, almost 12,500 of the total medical student population came from families with gross incomes of less than \$12,000."

Because of the high interest rates and security situation existing in commercial banks, students are extremely low on the "good risk" list for potential loans. It is here that AMA-ERF funds insure loans by **guaranteeing** repayment to the banks involved. Each dollar contributed to the Loan Guarantee Fund releases \$12.50 working capital in loans made by a commercial bank. As loans are repaid, money in the fund again becomes available to guarantee more loans.

To continue their support of AMA-ERF, the Woman's Auxiliary in Maryland has launched its annual sale of Christmas cards on a statewide basis. Kits are already in the hands of County Auxiliary AMA-ERF chairmen, and are circulating among the Auxiliary's Members-At-Large. Commissions from the sale of Christmas cards in 1970 and 1971 netted the Woman's Auxiliary \$1,382.15 for AMA-ERF.

With the continued faithful support of Maryland physicians and the diligent efforts of all Auxiliary members, Maryland's ERF program can insure much needed unrestricted funds for Maryland's two major medical schools—the University of Maryland and The Johns Hopkins University. In addition, it can provide financial aid for the use of Maryland's young medical students, interns, and residents through the Student Loan Guarantee Fund.



# Book Reviews

**THE HUMAN HEART, A Guide to Heart Disease, Brendan Phibbs, MD; Lane Craddock, MD; Robert T. Patrick, MD; and Colin H. M. Walker, MD; The C. V. Mosby Company, St. Louis, Missouri, 1971.**

This is the second edition of this paperback book that has received wide acclaim and circulation since it was first published. This is an excellent teaching aid for the patient and was developed by physicians for this purpose. It talks in easy-to-understand layman's language about heart disorders—how the heart works, what makes it beat, and what that beat accomplishes.

Perhaps the most important accomplishment is in telling what the patient can do to manage his own disease, since this is ultimately what the heart patient must do.

We can recommend it to all physicians for use by their patients.

**REVIEW OF MEDICAL PHYSIOLOGY, William F. Ganong, MD; Lange Medical Publications, Los Altos, California, 1971.**

This soft-cover book provides a concise summary of mammalian and, particularly, of human physiology which medical students and others can supplement with readings in current texts, monographs, and reviews.

This marks the fifth edition of this publication which has been published also in Portuguese, German, Italian, Spanish, and Japanese. Polish, Greek, and Turkish translations are on the way.

The worldwide acceptance of this book speaks for itself.

**TEETH, TEETH, TEETH, Sydney Garfield, DDS; Simon and Schuster, New York City, 1971.**

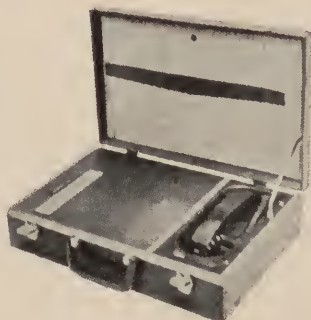
This treatise on teeth and related parts deals not only with man, but with land and water animals as well. It is a comprehensive book about teeth from the beginning of time to the present.

Whether or not it can be considered truly scientific is not known, but it makes interesting reading and is a publication the Literary Guild found enjoyable enough to select as one of its choices.

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For additional information about the Beecham-Massengill Total Service Concept see our representative or write to us directly.

**PRESCRIBING INFORMATION** **Indications:** Primarily for treatment of infections due to susceptible strains of *Pseudomonas aeruginosa*, *Proteus* species (particularly indole-positive strains), and certain *Escherichia coli*. Clinical effectiveness has been demonstrated in the following infections when due to these organisms: Urinary tract infections; severe systemic infections and septicemia; acute and chronic respiratory infections (while clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis); soft tissue infections. Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: **Gram-Negative Organisms**—*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morganii*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. **Gram-Positive Organisms**—*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** **Hypersensitivity Reactions**—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. **Gastrointestinal Disturbances**—Nausea. **Hemic and Lymphatic Systems**—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. **Hepatic and Renal Studies**—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. **Central Nervous System**—Convulsions or neuromuscular irritability could occur with excessively high serum levels. **Local Reactions**—Pain at the site of injection, sometimes accompanied by induration. **Vein Irritation and Thrombophlebitis**—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials. *Before prescribing or administering, see package circular or PDR.*





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# MEDICAL NEWS

Congratulations are in order to these Maryland MDs who have recently been accepted as new fellows of the American College of Physicians: **Raymond D. Bahr**, **Thomas B. Connor**, **Thomas R. Hendrix**, **Harry M. Robinson, Jr.**, and **Gustav C. Voight**—all from Baltimore. Also: **Werner F. Barth**, Bethesda; **William H. Wood, Jr.**, Easton; and **George M. Grames**, Potomac.

\*\*\*

**Yu-Chen Lee, MD**, Baltimore, has been granted Fellowship in the American College of Cardiology, the national medical society for specialists in cardiovascular diseases.

\*\*\*

A Baltimore pediatrician, **Murray Kappelman, MD**, had his first book, a novel about a pediatric ward in a city hospital, published last month. Called *The Child Healers*, the book exposes what he calls "the delicate balance between a doctor's stethoscope and his feelings which must be kept to insure both a fine physician and a fine human being".

Dr. Kappelman is associate professor of pediatrics at the University of Maryland, assistant professor at The Johns Hopkins Medical School, and director of pediatric ambulatory services at the University of Maryland.

\*\*\*

**Arthur Baitch, MD**, was recently elected chief of staff of the Baltimore County General Hospital. He is on the orthopaedic staffs of several Baltimore area hospitals. Dr. Baitch also instructs in the orthopaedic departments of The Johns Hopkins and University of Maryland schools of medicine.

Numerous physicians have received promotions for the academic year, as announced by **John H. Moxley, MD**, dean of the University of Maryland School of Medicine.

Acting director of the division of child psychiatry: **Taghi Modarressi**.

Professor: **C. Thomas Flotte**. (Dr. Flotte also serves as editor of this journal.)

Associate professor: **Robert C. Adams**, **Lawrence Donner**, **James P. Durkan**, **Herbert S. Gross**, **Robert H. Johnson**, **Marshall Renells**.

Assistant professor: **Michael N. Ashman**, **Leon Kochman**, **Arthur C. Lamb**, **Prasarn Nilprabhassorn**, **Richard K. Sakai**, **Emanuel Silverstein**, **Bahram Sina**, **Sylvester Steri-off**, **Charles M. Suter**, **Rodrigo Toro**, **Eugene Tudino**, **Celeste L. Woodward**.

Clinical assistant professor: **Lester H. Caplan**, **Robert G. Lancaster**, **Paul A. Mullan**, **Clayton Norton**, **Neil Novin**, **Boris L. Omansky**, **Sherman S. Robinson**, **Willard E. Standiford**, **James E. Taylor**, **Arnold Tramer**, **Arnold L. Vance**, **Maxwell N. Weisman**.

Instructor: **Dr. Brigita M. Krompholz**, **Ralph Weber**.

Professor and chairman of the department of surgery: **G. Robert Mason**.

Professor: **Willard M. Allen**, **Samuel I. Joseph**, **Eugene Kaplan**, **Gardner Smith**, **William D. Tigertt**.

Associate professor: **Richard A. Currie**, **Edward Davens**, **Julio H. Garcia**, **Fred L. Ginn**, **Richard A. Goldsby**, **Paul G. Mueller**, **Melvin D. Reuber**, **Carroll L. Spurling**, **Jean R. Stifler**.

Clinical associate professor: **Robert W. Gibson**.

Assistant professor: **Antti U. Arstila**, **LeRoy T. Davis**, **R. Ben Dawson**, **James E. Dunn**, **Ranier M. E. Engel**, **Leslie J. Fisher**, **Magdi G. Henein**, **Ronica Kluge**, **Anant Kusakull**, **Herbert Kushner**, **William T. Layman**, **John R. Lilly**, **John R. Lion**, **Sidney Marks**, **Joseph V. Osterman**, **Alfred F. Parisi**, **Robert G. Slawson**, **Paul V. Slater**, **W. Haddox Sothoron**, **Harold Standiford**, **Andrew J. Vola**.

Clinical assistant professor: **Ronald M. Barry**, **Mary A. Fox**, **Wilson Grubb**, **Edward W. Hopkins**, **Charles L. Randol**, **Charles M. Reilly**, **Benjamin White**.

Instructor: **Adil Al-Attar**, **Larry Becker**, **Robert Chabon**, **John J. Conroy**, **William A. Dear**, **Gary L. Ehrlich**, **Earlie H. Francis**, **John W. Gareis**, **David J. Gillis**, **Jose Raphael Garcia**, **Louis E. Grenzer**, **N. J. Haddah**, **Alice Heisler Hayeo**, **Meena Hazra**, **Nancy Kohn**, **Hae Son Lee**, **Martha B. Leffler**, **Elizabeth M. McDowell**, **J. David Nagel**, **Merrill C. Raikes**, **E. Lee Robbins**, **Solomon Robbins**, **Barry N. Rosenbaum**, **Shankar C. Sanwalani**, **Marcia C. Schmidt**, **Hector I. Solano**, **Joel V. Tolentino**, **Richard L. Violand, Jr.**, **Stephen L. Winter**.

Clinical instructor: **Merrill I. Berman**, **Ramond Boza**, **Robert D. Frieman**.

Research associate: **Paul R. Barnes**, **Junichiro Kawamura**, **David R. Livengood**, **Henry C. Nipper**, **Quentin A. Pletsch**, **Bernard J. Salmon**, **David B. Yelton**.

Consultant: **Howard T. Go**.



\*\*\*

A listing follows of general practitioners in Maryland who have successfully completed the requirements of the Board in recent certifying examinations. Each physician is now a charter Diplomate of the American Board of Family Practice, an organization fostered by the AMA to make general practice a special field. Congratulations to all of you!

Earl M. Beardsley  
Leon William Berube  
Joseph M. Caricofe  
John T. Chissell  
Ernest E. Cornelsen  
Robert W. Farr  
Marion Friedman  
Eugene Guazzo  
Krishan Lal Gupta  
Joseph Roy Guyther  
Thomas Franklyn Herbert  
Benjamin Highstein  
G. Overton Himmelwright  
Frederick M. Johnson  
Harry L. Knipp  
Keaciel Kenneth Krulevitz  
Leon R. Levitsky  
John Richard Lilly  
J. Nelson McKay  
Alfred R. Maryanov  
Phillip W. Mercer  
William R. O'Rourke  
Theodore E. Patrick  
William Harvey Patrick  
Morris Perry  
Edward Joseph Richards  
Charles Joseph Savarese, Jr.  
William L. Stewart  
Joseph Taler  
Frank B. Thomas, III  
Peter V. Thorpe  
Howard Nelson Weeks  
Daniel I. Welliver  
Milton D. Westberg  
Charles Herman Williams  
Robert Henry Williams  
Robert C. Wingfield  
Paul G. H. Wolber

\*\*\*

**Graves' disease** — Cooperation of physicians is requested in the referral of patients with active and progressive eye changes of Graves' disease for study and treatment by the Endocrinology Service of NIH.

Upon completion of stud-

ies, patients will be returned to the care of the referring physician who will receive a summary of findings and recommendations for further therapy.

Physicians interested in having their patients considered for admission may write or telephone Peter O. Kohler, MD, or Griff T. Ross, MD, Clinical Center, Room 10B-09, National Institutes of Health, Bethesda, Maryland 20014, telephone 301-496-4686.

\*\*\*

**Leukemia research** — Applications to support scientific research in leukemia and related disorders will be accepted by the Leukemia Society of America, Inc., until November 1, 1971. Applications will be reviewed in January and grants commence in July.

Applications and information may be obtained by writing: Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 E. 43rd St., New York, N.Y. 10017.

\*\*\*

**George Robert Mason, MD**, has been appointed chairman of the department of surgery of the University of Maryland's School of Medicine.

A graduate of the University of Chicago School of Medicine, Dr. Mason was associate professor of surgery at Stanford, where he did extensive research in gastrointestinal physiology.

He replaces the former surgery chairman, Robert W. Buxton, MD, who died from injuries received in an automobile accident last year. Arlie R. Mansberger, MD, professor of surgery, served as acting chairman in the interim.

Commenting on the appointment, Dean Moxley de-

scribed Dr. Mason as "not only a distinguished surgeon, but an active teacher and investigator".

In addition to his MD degree, Dr. Mason holds a BA from Oberlin College and a PhD in physiology from Stanford. The 39-year-old native of Rochester, N.Y., interned at the University of Chicago. In 1969 he was named a John and Mary R. Markle Scholar in Academic Medicine, an appointment he holds through 1974. He is a member of Alpha Omega Alpha and a Diplomate of the American Board of Surgery and the Board of Thoracic Surgery.

\*\*\*

**Journalism awards**—In 1964 the AMA initiated annual Medical Journalism Award competition. This award has cited more than 150 journalists in all media.

Deadline for 1971 entries is February 1, 1972. If you know of any journalists whom you feel have made distinguished contributions toward keeping society medically informed urge them to submit their work for adequate recognition. Further information may be secured from the Medical Journalism Awards Committee, American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610.

\*\*\*

**Melvin Grumbach, MD**, director of Pediatric Services, University of California School of Medicine, has been chosen by the American Academy of Pediatrics to receive its 1971 Borden Award. The award is made for outstanding achievement in research relating to nutrition. Dr. Grumbach will be remembered by many Marylanders for, in the 1950s, he served as a post-doctoral fellow as well as as-



sistant in pediatrics at Johns Hopkins.

\*\*\*

**George H. Yeager, MD**, Baltimore, is serving as Maryland Councilor to the Southern Medical Association. Joining him as Associate Councilors are these physicians: **Eldon G. Hoachlander**, Hagerstown; **Stephen N. Jones**, Rockville; **Howard F. Kinnamon, Jr.**, Easton; and **John O. Sharrett** and **John A. Wagner**, Baltimore.

\*\*\*

### FLU SHOTS URGED

Persons involved in occupations concerned with public safety, public utilities, or other specialized public services who have made a practice of taking influenza shots should continue with them this fall. So says **Howard J. Garber**, chief of the division of communicable diseases for the State Department of Health and Mental Hygiene.

While it is unlikely that B-type influenza will present any significant problem this year because of its widespread outbreak last season, Dr. Garber predicts that Marylanders can expect some localized outbreaks of Hong Kong Influenza this winter.

The vaccine is recommended for all persons over 65 years of age and for chronically ill of all ages who suffer from heart, lung, kidney diseases, or diabetes. Persons living in nursing homes, chronic disease hospitals, and other medical institutions where living arrangements may facilitate the spread of influenza should also receive the vaccine.

Vaccination is not recommended for children unless they fall in the high-risk group of the chronically ill.

Immunization should be completed by December 1.

### CARDIOLOGY STUDY

The American College of Cardiology has launched a 15-month study of what the United States has and needs in professional manpower for cardiovascular diseases.

The College is serving as administrator for a \$126,655 National Heart and Lung Institute contract to evaluate cardiology training and manpower requirements in patient care, teaching and research. The study will include questionnaires to several thousand practicing cardiologists and other physicians who have a primary interest in this area of medicine. Other information will be gathered through daily accounts of how cardiologists spend their time.

**Forrest H. Adams, MD**, ACC President and principal investigator, reports: "The data collected will provide a description of current practices and will identify needs and opportunity for future training in cardiology."

The rationale behind the study, Dr. Adams said, is the belief that "recently introduced methods in the diagnosis and treatment of cardiovascular diseases are effective only if skilled physicians and other personnel become available to deliver optimal health care".

The study's specific purposes will be 1) to define the current professional role of the cardiologist; 2) to determine the objectives of training programs in cardiology; 3) to determine the current and future manpower needs; 4) to determine the current and future educational needs of cardiologists; and 5) to prepare the results of the study for dissemination and to make recommendations to the National Heart and Lung Institute

for improving the availability of manpower in this field.

\*\*\*

### FLORIDA LICENSES

As of September 1, the Board of Medical Examiners of Florida began issuing licenses by endorsement to practice medicine and surgery in Florida. An amendment to the Medical Practice Act of Florida, enacted by the 1971 legislature, allows issuance of licenses by endorsement to those MDs who have been certified by the National Board of Medical Examiners or the Federation Licensure Examination within a period of eight years preceding the date of application for licensure by endorsement. Therefore, an MD must have been certified by the National Board of Medical Examiners since September 1, 1963, in order to initially be eligible for licensure by endorsement. As to other state licensure examinations, this amendment only applies to those states who use FLEX as their licensure examination.

In the case of foreign medical graduates, this does not eliminate the requirement that the MD have papers of first intention of citizenship and a minimum of one year's residency in the United States and the Educational Council for Foreign Medical Graduates Certificate of proficiency. A very important feature of the amendment is the provision that a physician who receives a license by endorsement in Florida must practice in the state within a period of three years for a minimum period of one year. If he does not do this the license will become null and void. Service in the armed forces is exempt during these three years, but internship or residency time is not exempt.

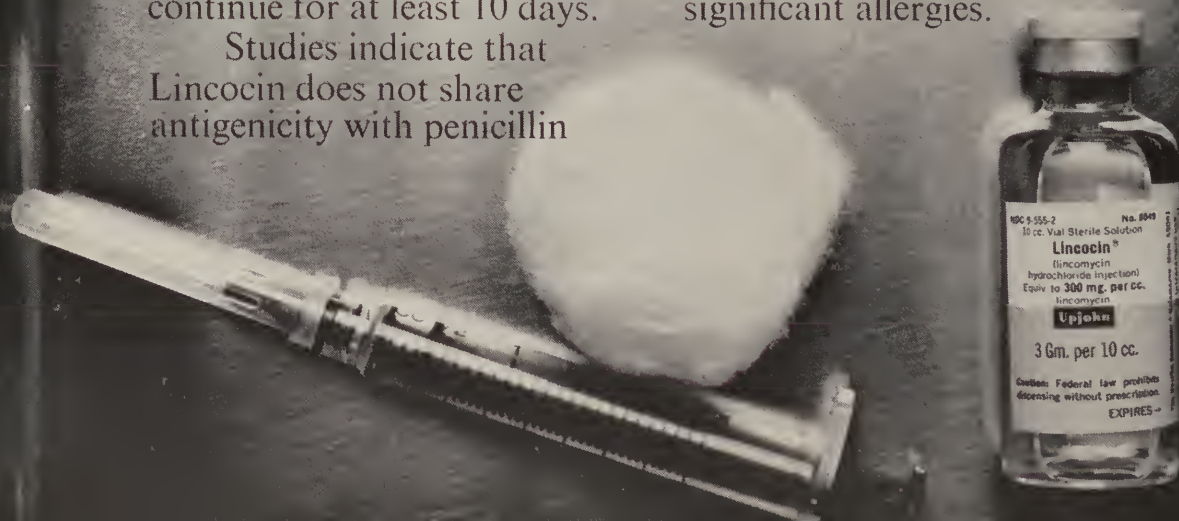


# Hypersensitivity to penicillin is a good reason to consider Lincocin® (lincomycin hydrochloride)

Lincocin (lincomycin hydrochloride, Upjohn) has produced a high percentage of satisfactory responses in patients with mild, moderate and severe infections due to susceptible streptococci, pneumococci and staphylococci (including many penicillinase-producing strains). With  $\beta$ -hemolytic streptococcal infections, treatment should continue for at least 10 days.

Studies indicate that Lincocin does not share antigenicity with penicillin

compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.





# So is penicillin-resistant staph.

Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with

all antibiotics, susceptibility studies should be performed.

Intramuscular and intravenous injections of Lincocin (lincomycin hydrochloride, Upjohn) are generally well tolerated. Instances of hypotension following parenteral administration have been reported, particularly after too rapid intravenous administration.

## Sterile Solution (300 mg. per ml.) **Lincocin®** (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.





# Lincocin<sup>®</sup>

(lincomycin hydrochloride, Upjohn)

## for respiratory tract, skin, soft-tissue, and bone infections due to susceptible streptococci, pneumococci, and staphylococci

Each preparation contains: Lincomycin hydrochloride monohydrate equivalent to lincomycin base

250 mg. Pediatric Capsule . . . . . 250 mg.  
 500 mg. Capsule . . . . . 500 mg.  
 \*Sterile Solution per 1 ml. . . . . 300 mg.  
 Syrup per 5 ml. . . . . 250 mg.  
 \*Contains also: Benzyl Alcohol 9 mg.; and, Water for Injection—q.s.

An antibiotic chemically distinct from others available, indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed.

**CONTRAINDICATIONS:** History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or

significant allergies. Overgrowth of non-susceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonal treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angio-neurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.

*Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg. and 500 mg. Capsules—bottles of 24 and 100.

*Sterile Solution, 300 mg. per ml.*—2 and 10 ml. vials and 2 ml. syringe.

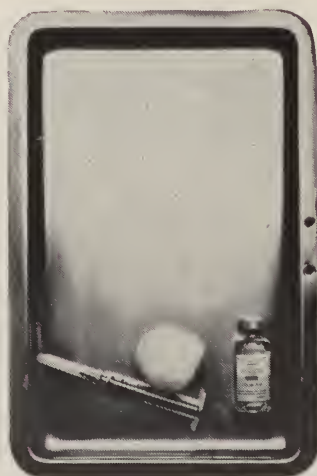
*Syrup, 250 mg. per 5 ml.*—60 ml. and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

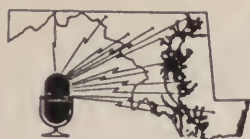
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# MEDIC

## 1971 SCHEDULE

### OF POSTGRADUATE PROGRAMS

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**October 22, 1971 12:30 PM**

#### **HYPERLIPIDEMIA**

**Simeon Margolis, MD**  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, October 25, 1971 12:30 PM  
Wednesday, October 27, 1971 9:00 AM  
2:00 PM

**October 29, 1971 12:30 PM**

#### **MANAGEMENT OF ADULT ONSET DIABETES**

**Thaddeus E. Prout, MD**  
Chief of Medicine  
Greater Baltimore Medical Center  
Associate Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Baltimore County General Hospital**

Replays: Monday, Nov. 1, 1971 12:30 PM  
Wednesday, Nov. 3, 1971 9:00 AM  
2:00 PM

**November 5, 1971 12:30 PM**

#### **THE CHEST FILM AS A MIRROR OF PULMONARY PHYSIOLOGY**

**Theodore Keats, MD**  
Chairman and Professor of Diagnostic Radiology  
University of Virginia School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, Nov. 8, 1971 12:30 PM  
Wednesday, Nov. 10, 1971 9:00 AM  
2:00 PM

**November 12, 1971 12:30 PM**

#### **CLINICAL PROBLEMS IN THE MANAGEMENT OF SPINAL CORD INJURY**

**Arthur P. Siebens, MD**  
Professor of Rehabilitation Medicine  
Professor of Rehabilitation Surgery  
Johns Hopkins University School of Medicine  
Rehabilitation Physician-In-Chief  
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, Nov. 15, 1971 12:30 PM  
Wednesday, Nov. 17, 1971 9:00 AM  
2:00 PM

#### **CONTINUING PROGRAMS**

**(Heard at participating hospitals only)**

#### **SATURDAY MORNINGS—11:30 AM**

**CONJOINT CLINIC**  
Johns Hopkins University  
(September-May)

#### **TUESDAY MORNINGS—11:30 AM**

**MEDICAL GRAND ROUNDS**  
University of Maryland Hospital  
(September-May)

#### **WEDNESDAYS—12 NOON**

**C. P. C.**  
The Johns Hopkins Hospital  
(September-May)

#### **SATURDAY MORNINGS—10:00 AM**

**MEDICAL GRAND ROUNDS**  
The Johns Hopkins Hospital  
(September-May)

#### **SATURDAY MORNINGS—8:30 AM**

**PEDIATRIC GRAND ROUNDS**  
The Johns Hopkins Hospital  
(All Year)

#### **SPONSORS:**

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of Maryland

State Department of Health and Mental  
Hygiene

Hospital Association of Maryland

#### **For further information contact:**

**MEDIC**  
1211 Cathedral Street, Baltimore, Maryland 21201  
539-0872



November 19, 1971 12:30 PM

### ISONIAZIDE PROPHYLAXIS FOR TUBERCULOSIS

**Edmund G. Beacham, MD**  
Chief Chronic Medical Care  
Baltimore City Hospitals  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**Allan S. Moodie, MD, MB, DPH**  
Director, Bureau of Communicable Diseases  
Baltimore City Health Department

**Sponsor: Baltimore City Hospitals**

Replays: Monday, Nov. 22, 1971 12:30 PM  
Wednesday, Nov. 24, 1971 9:00 AM  
2:00 PM

November 26, 1971 12:30 PM

### TECHNIQUES OF MANAGEMENT IN DIABETES

**Dean H. Lockwood, MD**  
Assistant Professor of Medicine  
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, Nov. 29, 1971 12:30 PM  
Wednesday, Dec. 1, 1971 9:00 AM  
2:00 PM

#### Participating hospitals:

Anne Arundel General, Annapolis  
Baltimore City, Baltimore  
Baltimore County General, Randallstown  
Bon Secours, Baltimore  
Calvert County, Prince Frederick  
Carroll County General, Westminster  
Church Home, Baltimore  
Cumberland Memorial, Cumberland  
Easton Memorial, Easton  
Edward McCready, Crisfield  
Eugene Leland Memorial, Riverdale  
Frederick Memorial, Frederick  
Good Samaritan, Baltimore  
Greater Baltimore Medical Center, Towson  
Harford Memorial, Havre de Grace  
The Johns Hopkins, Baltimore  
Kent & Queen Anne's, Chestertown  
Keswick, Baltimore  
Lutheran, Baltimore  
Malcolm Grow Medical Center, Andrews Air Force Base  
Maryland General, Baltimore  
Mercy, Baltimore  
Montgomery General, Olney  
North Charles General, Baltimore  
Peninsula General, Salisbury  
Physicians Memorial, LaPlata  
Provident, Baltimore  
Sacred Heart, Cumberland  
St. Agnes, Baltimore  
St. Joseph, Baltimore  
St. Mary's, Leonardtown  
Sinai, Baltimore  
University of Maryland, Baltimore  
Union Hospital of Cecil County, Elkton  
Union Memorial, Baltimore  
Washington County, Hagerstown

#### Other locations:

Baltimore County Health Dept., Towson  
Civil Defense Headquarters, Baltimore  
Hospital Association of Maryland, Inc., Baltimore  
Medical and Chirurgical Faculty, Baltimore  
State Department of Health, Baltimore

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*When ephedrine is too exciting  
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### **MUDRANE GG**

*During pregnancy or when K.I. is  
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*A counterpart for Mudrane-2*

### **MUDRANE GG ELIXIR**

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their Atropine content . . .  
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS  
3rd Edition, page 522



# ANTROCOL<sup>®</sup>

*Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.*



Each tablet or capsule contains:  
Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

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100, 500 and 5000  
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Caution: Federal law prohibits  
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#### PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

**DOSAGE:** One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

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A Health, Education and Welfare Commission has been formed to study the entire range of medical malpractice problems.

The commission will conduct a series of public hearings on the fundamental causes behind the rising number of malpractice claims and their effects on the health-care system, the legal system, the insurance industry, and the general public.

In announcing the commission's membership, HEW Secretary Elliot Richardson said, "I feel confident this outstanding group will make a major contribution towards solving one of the nation's most vexing health care problems."

Headed by Attorney Wendell Freeland of Pittsburgh, Pennsylvania, the newly created secretary's Commission on Medical Malpractice will represent health-care providers and institutions, the legal profession, the insurance industry, and the general public. Acting as additional consultants to the commission will be advisory panels comprised of experts in the disciplines directly concerned.

The commission will compile statistical data and other relevant information in a series of studies conducted by HEW primarily through contracts with nongovernment research organizations and universities.

Eli P. Bernzweig, HEW's specialist in the medical malpractice area, has been named executive director of the commission staff. Loren F. Taylor, MD, professor of anesthesiology at the University of Kansas Medical Center, has been named deputy executive director.

The commission will make



a final report with recommendations to the HEW Secretary.

Charles Hoffman, MD, president-elect of the American Medical Association and member of the AMA Board of Trustees, is one of the commission members. Others are: Vincent H. Cohen, Hogan and Hartson, Washington, D.C.; Bernard J. Conway, Assistant Executive Director, American Dental Association; Mrs. Helen Creighton, RN, LLD, Professor of Nursing, University of Wisc.-Milwaukee; William J. Curran, LLD, SM Hygiene, Professor of Legal Medicine, Harvard Medical School; Wendell Freeland, Pittsburgh; Howard Hassard, Hassard, Bonnington, Rogers & Huber, San Francisco; Paul B. Jarrett, MD, Phoenix, Ariz.; Henry T. Kramer, President; N. American Reinsurance Corp; John E. Linster, Senior Vice-President, Employers Insurance of Wausau, Wausau, Wisc.; James E. Ludlam, Musick, Peeler & Garrett, Los Angeles; Richard M. Markus, Sindell, Sindell, Bourne, Markus, Stern and Spero, Cleveland; Edward H. Morgan, Assistant Secretary, Casualty

Underwriting-Dept. Cll, Aetna Casualty and Surety Co., Hartford, Conn.; George W. Northup, DO, Editor, American Osteopathic Association Journal, Livingston, N.J.; Miss Audra Marie Pambrun, RN, Director, Community Health Aides, Blackfee Community Action Program, Browning, Mont.; Mrs. Esther G. Schiff, Legal Counsel, Mt. Sinai Hospital of Greater Miami, Miami Beach, Fla.; Monroe E. Trout, MD, JD, New Canaan, Conn.; and Carl E. Wasmuth, MD, JD, Chairman, Board of Governors, The Cleveland Clinic Foundation, Cleveland, Ohio.

\* \* \*

**President Nixon's sweeping economic proposals have pushed aside chances for congressional hearings on national health insurance until after the first of the year.**

Four of the Nixon economic proposals require legislative action and this will keep the House Ways and Means Committee busy at least through September and probably longer. Coupled with the Congress' announced intention of adjourning in late October or early November, this could delay congressional action on national health insurance until late 1972, or possibly until the convening of a new congress in 1973.

While the House Ways and Means Committee considers the Nixon economic proposals, the Senate Finance Committee will consider the Social Security Amendments (H.R. 1) already passed by the House. Chances are that the Senate will delete the Administration's welfare proposals (Family Assistance Plan) from H.R. 1 and add Senator Wallace F. Bennett's (R-Utah) Professional Standards



Review Organization proposal of last year. Enactment of this legislation prior to adjournment is considered likely.

Also considered likely to be enacted prior to adjournment are the health manpower bills presently in conference. This legislation would authorize an estimated \$3.3 billion in aid to health profession students and their schools in the next three years and provide facilities and program to close the manpower shortages in the health professions within seven years.

\* \* \*

**The President of the American Medical Association, Wesley W. Hall, MD, recently praised the nation's press for a "growing sophistication" in dealing with health-care issues.**

Speaking before an audience of newsmen, federal officials, and health organization representatives at the National Press Club in Washington, D.C., Dr. Hall said, "This is a most healthy development." Many news stories now analyze the issues raised and challenge and dispute assumptions rather than follow a "hackneyed theme," he said.

"If the people are fully informed, we doctors of America will put our trust in their ability to make the right de-

cisions . . . I find it encouraging that the press is approaching this subject with maturity, with skepticism and, most of all, with an open mind."

Noting that the AMA's Medcredit bill has attracted over 150 sponsors, Dr. Hall said this doesn't mean that Medcredit is going to be enacted but does "mean that a substantial number of congressmen and senators agree with the principles that we used in drawing up a program and offering it to Congress."

Dr. Hall said Medcredit makes available to everyone under 65 a private program of complete medical and health-care protection, covering both the ordinary and the catastrophic expenses of illness or accident.

"The protection can be a health insurance policy, membership in a prepayment plan or membership in a prepaid group practice. Each patient is left free to choose the kind of care he wants, and each physician is left free to practice as he wishes—alone or with other physicians."

The most important thing about Medcredit, said the AMA official, is that it maintains freedom for the patient as well as for the physicians.

"We believe that there is a lot of good in the present system. Two million Americans

a day see their doctor, and although this probably is not all who should see a doctor, there is no reason to throw out the system that has this capacity. Rather we should build on it."

\* \* \*

The AMA's often expressed desire to see the establishment of a separate Department of Health with cabinet status has again been brought to the public's attention with the announcement of Congressman Paul G. Rogers (D-Fla.), chairman of the House's subcommittee on health, that he will shortly introduce such a measure.

During the past ten years or so, health has mushroomed as an economic force in American life, and as a function of government. Neither Congress nor the executive branch has been able to keep pace organizationally with the changes.

Congressman Rogers' call for a separate health department is considered to be part and parcel of this behind-the-scenes jockeying by the Congress for more authority in health-care matters. If a Department of Health was established, Rogers' subcommittee could claim authority over all of the activities of the new department and drive to establish a permanent full committee on health.



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A comprehensive actuarial study of all of the major proposals for national health insurance arrangements prepared by HEW has been released for the information of congressional committees studying the issue.

The actuarial report's prediction of gross underfinancing in the Kennedy proposal for federal assumption of the bulk of health-care costs was the most noteworthy item in the 83-page report. The work was reviewed by outside experts to check on its fairness and soundness.

The major plans before Congress would compare in terms of additional costs to the government as follows:

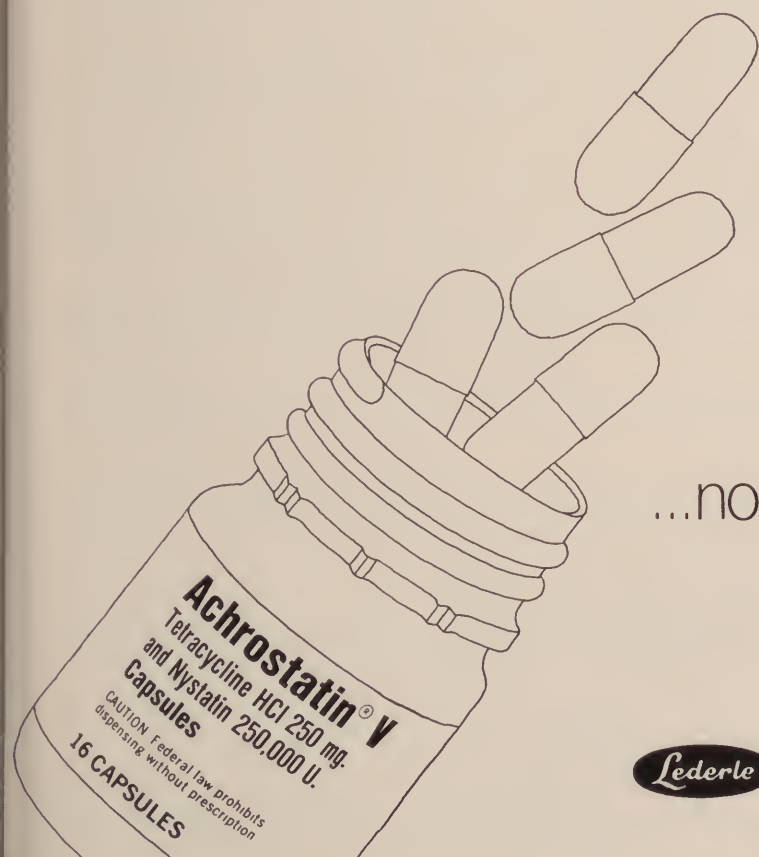
Administration—\$2.6 billion

Kennedy—\$59.4 billion  
Medicredit (backed by the AMA)—\$6.3 billion  
Burleson (the health insurance industry plan)—\$7.3 billion  
Javits (medicare for all)—\$41.6 billion  
Hall-Long (catastrophic only)—\$3.2 billion, \$3.1 billion  
Pell-Mondale (mandated employer plans, health care corporations)—\$4.9 billion

For the most part, these costs represent "transferred" spending from the private sector. In the case of Medicredit, financed largely by tax credits for purchase of comprehensive private insurance, most of the "cost" represents a revenue loss rather than an additional expense.

The HEW report said overall federal spending under the Kennedy bill, including existing programs it would take over, would total \$81.6 billion in the fiscal year 1974, but that the proposed financing would raise only \$57 billion. Thus, it would be underfinanced by 43%, or \$24.6 billion.

National health expenditures of all kinds will rise to \$105.4 billion in fiscal 1974, an average increase of 12% a year, if none of the major proposals is enacted. Operation of the Kennedy program in fiscal 1974 would result in total U.S. health spending (government and private) of \$113.8 billion; the administration bill, \$107.2 billion; the insurance industry bill, \$110 billion; and Medicredit, \$109.5 billion.



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# **your medical faculty at work**

**by John Sargeant**  
**Executive Director**

The Executive Committee met on Saturday, September 11, 1971, and took the following actions:

1. Received information regarding the new proposed communicable disease regulations, approving them in principle with the understanding they will be submitted for further review when they are in final form.
2. Approved the House of Delegates minutes for sessions on May 12 and May 14, 1971.
3. Authorized appointments to represent the Faculty as follows:
  - a) Professional Practices Committee of the Maryland Hospital Association: Melvin A. Borden, MD, Baltimore.
  - b) Advisory Committee on Adoption, State Department of Social Services: Harry M. Beck, MD, Baltimore; or Joseph T. Michels, MD, Baltimore.
  - c) Advisory Committee on Foster Care, State Department of Social Services: John Cassidy, MD, Bethesda; or Clayton Norton, MD, Severna Park.
  - d) Advisory Council on Clinical Investigations: Francis Borges, MD, Baltimore; or C. Thomas Flotte, MD, Baltimore.
4. Agreed to co-sponsor the following two meetings:
  - a) Jointly with the AMA, the Regional Conference on Relationships Between State Medical Associations and Voluntary Health Agencies, scheduled for Sunday, April 9, 1972, at Atlanta, Ga.
  - b) Jointly with the Maryland Hospital Association, a Workshop on New Standards for Accreditation of Hospitals, date, time and place to be announced.
5. Reaffirmed the Faculty's position with respect to any delegation of those duties now defined as the practice of medicine, so they are subject to regulation by the Board of Medical Examiners.
6. Agreed to cooperate in any way possible with any projected Health Manpower survey in the state that may be undertaken.
7. Heard that arrangements had been completed for assumption of the work formerly done by the Department of Health and Mental Hygiene in connection with the MEDIC program; with the Department underwriting the Faculty's costs in this connection.
8. Heard that the Faculty's membership records were being converted to data processing and that this joint effort with the AMA of maintenance of one file record was being used as a pilot study in this regard.
9. Adopted a resolution concurring in the development of a Uniform System of Data Collection on Hospital Discharges.
10. Declined to investigate the fund raising activities of voluntary agencies because it was felt this was not within the jurisdiction of the Faculty; but agreed to refer to the Mediation Committee several questions regarding the ethics of physicians who are involved in voluntary health agency activities. A report will be made in this regard.
11. Heard that a study is being undertaken jointly by the Regional Medical Program and the Faculty in connection with hospital privileges of all Maryland physicians; to ascertain those who do not have such privileges and the reasons, if possible, for their not having such privileges.
12. Approved the expenditure of up to \$1,000 for support of a seminar on Improvement of Care in Chronic Disease Facilities set for November 13, 1971.
13. Directed the Executive Director to develop a list of appropriate home dialysis equipment, together with pertinent information such as repair capabilities, for use by Maryland Blue Cross and other interested groups.



14. Submitted the following names for consideration of the Secretary of Health and Mental Hygiene for appointment to the Maryland Emergency Care Advisory Council:  
 H. Vincent Davis, MD, Chesapeake City  
 Haluk B. Boneval, MD, Cheverly  
 Gunther D. Hirsch, MD, Havre de Grace
15. Reaffirmed its opposition, with the Board of Medical Examiners to be so notified, to temporary licensure so that unlicensed physicians could treat patients in state mental institutions. In doing so, it pointed out the difficulties of restricting this to one category of physicians; to the possibility that such persons may have failed licensure examinations; and that rendering of care to patients in state institutions might result in lack of endeavor to recruit fully qualified persons for the posts.
16. Agreed to request representatives of the Social Security Administration to attend the next Executive Committee session to discuss the mechanisms currently used in their relations with private physicians who have patients participating in research projects at the SSA headquarters in Woodlawn.
17. Referred to the Subcommittee on Medical Emergency Services, the request from Mary S. Furth, MD, of the Maryland Poison Information Center, that the Faculty maintain a new reference manual for available medical facilities, as well as distribute them to all physicians.
18. Agreed to notify the Maryland Podiatry Association the present law requires the Board of Medical Examiners to name members of the Podiatry Board from the entire membership of that association. It suggests, however, that the Board of Medical Examiners may wish to consider specific names submitted for its consideration in making these appointments.
19. Agreed to advise the Maryland Podiatry Association the Faculty has no jurisdiction over hospital staff privileges, as well as internships and outpatient services, but that the Faculty already has adopted the same position as the Joint Commission on Accreditation of Hospitals with respect to podiatry hospital privileges.
20. Referred to the Council for its consideration the question of granting Associate Membership in the Faculty to podiatrists.
21. Approved a change in the composition of the Program and Arrangements Committee so that Edwin H. Stewart, MD, Baltimore, would commence his term of office at the conclusion of the 1971 Annual Meeting, vice William L. Stewart, MD, who has moved out of the state.
22. Reaffirmed its previous positions with respect to allocation of space at Annual and Semiannual sessions in descending order as follows: President and Program Committee Chairman; President-elect; and Council Chairman.
23. Voted that round-table discussions at the 1972 annual session be continued in the usual format with a diversification of scientific subjects.

The Council met on Saturday, September 11, 1971, and took the following actions:

1. Adopted minutes of previous meetings.
2. Adopted financial statements through June 30, 1971, a) Operating Funds Statement and b) Dedicated Funds Statement.
3. Adopted a resolution calling on the U.S. Congress and the U.S. President to grant a pardon to Samuel A. Mudd, MD, a native of Maryland and graduate of the University of Maryland School of Medicine in 1856, by declaring him innocent of any crime.
4. Endorsed the concept of a Maryland Foundation for Medical Care as proposed to the House of Delegates (see report on House of Delegates session).
5. Endorsed the concept as requested by the Peer Review Committee that in any federal legislation that may be adopted, peer review of physicians be conducted by physicians.
6. Agreed to a recommendation of the Mediation Committee that Findings of Fact as adopted by the Commission on Medical Discipline be published in full in the *Maryland State Medical Journal*, when final. This would be subject to legal advice obtained by the Commission.
7. Adopted Medical Standards for Skilled Nursing Homes as recommended by the Peer Review Committee and Subcommittee on Nursing Home Liaison.



8. Adopted a resolution for submission to the House of Delegates dealing with the use of amphetamines.
9. Adopted a resolution for submission to the House of Delegates dealing with the use of methadone.
10. Adopted a resolution for submission to the House of Delegates commending the Hospital Cost Analysis Service for its activity.
11. Accepted the Report of the Advisory Council on Human Trials and suggested that its title be changed to read Advisory Council on Clinical Investigation.
12. Approved turning over all memorabilia in possession of the Faculty to the Smithsonian Institute on indefinite loan with the understanding that appropriate credit will be given the Faculty when displays are made of any of the material.
13. Waived 1971 dues of a member because of illness at the request of a component society.

**The House of Delegates in Semiannual Session on Saturday, September 11, 1971, took the following actions:**

1. Adopted the recommendations of the Peer Review Committee in the following form:
  1. The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland approve the formation of a Maryland Foundation for Health Care.
  2. That its organizational structure be developed, in concert with other providers of health services, with an invitation being extended to other organized medical groups, including health-oriented consumer groups, to join with the medical profession in this endeavor.
  3. That appointment of the Board of Directors of the Maryland Foundation for Health Care be directly vested with the Council of the Medical and Chirurgical Faculty. In this manner, the Foundation would be a functioning body of the Faculty, just as various committees of the Faculty presently are.
  4. That the Council or House of Delegates approve the draft Bylaws, either as they are submitted or changed by either of these bodies, or approve them in principle, leaving final approval to the Board of Directors of the Foundation.
  5. The members of the House of Delegates of the Medical and Chirurgical Faculty shall be the voting members of the Foundation; with the Council being authorized to act (as it currently is authorized to do) between sessions of the House of Delegates. In addition, the Faculty's Executive Committee be designated as officers of the Foundation with the authority to make decisions of immediate importance (as is currently their responsibility for Faculty affairs).
  6. The Executive Director of the Faculty be the Chief Executive Officer of the Foundation.
  7. Other deliverers of Health Care be invited to join the Foundation, with representation on the Board to be determined, after discussions with such groups.
  8. That the purposes of the Foundation be adequately and clearly spelled out, with authority being given to the Council to approve the changes in Bylaws, etc., as needed or required.
  9. That sufficient funds for expenses involved in the development of the Foundation structure be advanced to the Foundation, with the understanding that as the Foundation becomes operational, charges be made to third parties for its activities; and that such funds would be repaid to the Faculty.
  10. That the Faculty's Peer Review Committee play an active and vital role in the Foundation operation.
2. Adopted the following recommendation of the Medical Economics Committee:  
*Resolved*, That the Council of the Medical and Chirurgical Faculty of Maryland be empowered and is hereby empowered to rescind the action of the House of Delegates, taken at the Annual Meeting in 1960, endorsing the St. Paul Companies as the official carrier of the Faculty for professional liability insurance program; and is also empowered to approve or endorse an alternative program if, in its opinion, such an alternative program is more desirable for the physicians of Maryland.
3. Approved the auditor's statement for the year 1970 as presented by the Treasurer.
4. Adopted the following resolution dealing with the use of amphetamines:



WHEREAS, The indiscriminate use of amphetamines by the general public has assumed alarming proportions; and

WHEREAS, Almost total bans on the prescribing of amphetamines and methamphetamines in other areas of the country have resulted in a heavy reduction in the number of such prescriptions written; and

WHEREAS, The dispensing of all drugs by physicians is discouraged through the Physician/Pharmacy Code of Cooperation; and

WHEREAS, It behooves every member of the medical profession to exert the utmost caution in prescribing or dispensing any drug with an abuse potential, be it

*Resolved*, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland goes on record as stressing the cooperation of all physicians in the state in ensuring that prescribing of amphetamines and methamphetamines is restricted to truly recognized cases of medical need.

5. Adopted the following resolution dealing with Hospital Cost Analysis Service:

WHEREAS, The Hospital Cost Analysis Service is a joint venture of various official groups involved in providing and payment of hospital care and services; and

WHEREAS, This organization in existence for the past 11 years has proven itself to be of inestimable value both in reducing costs of audits previously conducted by different, independent organizations; and

WHEREAS, In 1968 recognizing the need for extensive and effective efforts to be expended in the areas of hospital cost controls, it expanded to include this function; and

WHEREAS, Since that time it has been successful in reducing costs in various hospital departments that otherwise may not have occurred; and

WHEREAS, Recognition of this effective hospital cost containment program is evident through a grant from the U.S. Department of Health, Education and Welfare for a continuation of the program and a refinement of techniques used therein; and

WHEREAS, Recognition by local authorities should be made of this effective activity; be it

*Resolved*, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland goes on record as commending the Hospital Cost Analysis Service for its activities and for the effective measures developed by the Hospital Cost Containment Service to ensure that hospital funds are used in an effective and cost-efficient manner; and

*Resolved*, That a copy of this resolution be sent to the following groups: Hospital Cost Analysis Service, Hospital Cost Containment Program, Maryland Hospital Association, Department of Health and Mental Hygiene, Maryland Blue Cross, Inc., Health Insurance Association of America, U.S. Department of Health, Education and Welfare, and the newly appointed Health Services Cost Review Commission.

6. Adopted the following resolution dealing with the use of Methadone:

WHEREAS, Methadone (Dolophine) is an accepted method of treatment for hard-core narcotic addicts; and

WHEREAS, Methadone (Dolophine) is a widely used drug for the purpose of detoxification of such addicts; and

WHEREAS, It is a well known fact that narcotic addicts easily feign illness, pain and withdrawal symptoms to prey upon the compassion of the physician; and

WHEREAS, On occasion, physicians have proven susceptible to prescribing this drug for addicts without recognizing the serious problems they may be fostering; and

WHEREAS, Other suitable substitute drugs can be prescribed for legitimate cases needing a drug to alleviate pain; and

WHEREAS, It is deemed in the best interest of the public, as well as the physician population, to restrict access to this drug and see that it is used only for legitimate purposes; and

WHEREAS, Existing committees of the Medical and Chirurgical Faculty have been effectively controlling, as far as possible, any indiscriminate prescribing that is brought to its attention; and

WHEREAS, Such committees can and are willing to approve use of this drug, on request, for limited purposes and under strict supervision; be it

*Resolved*, That the Medical and Chirurgical Faculty of the State of Maryland jointly with the Secretary of Health and Mental Hygiene hereby requests all physicians in Maryland to cease use of this drug, except for controlled drug therapy programs that have a legitimate



IND number; in cases where specific urgent medical need exists; and in cases where special exceptions are approved by the Secretary of Health and Mental Hygiene after the recommendation by committees of the Faculty; and be it

*Resolved*, That this action be disseminated to all physicians in Maryland so they are fully aware of this restriction on the use of Methadone (Dolophine); and be it

*Resolved*, That the Maryland Pharmaceutical Society be informed of this action so that pharmacists and pharmacies in Maryland will also be aware of the restriction on the use of this drug and will notify the Division of Drug Control, State Department of Health and Mental Hygiene so that a review of such prescriptions may be undertaken by the appropriate Faculty committee.

## STATEMENT REGARDING USE OF MEDICATION IN TREATMENT OF CHILDREN WITH LEARNING DISABILITIES, BEHAVIORAL DISORDERS, AND EMOTIONAL PROBLEMS

*The following statement has been prepared by the Child Welfare Subcommittee and approved by the Executive Committee of the Medical and Chirurgical Faculty of the State of Maryland:*

The use of medication in the treatment of children with learning disabilities, behavioral disorders, and emotional problems is becoming more common. The recent discussion in the news media of the indiscriminate use of such medication is unfortunate in that it suggests to many worried parents that any use of such medication is wrong and it fails to note the many children in whom proper use of medication has prevented permanent educational and emotional damage.

The diagnosis of learning, behavioral, and emotional problems in children is neither simple nor easy. There are many possible origins, and treatment methods are different. The identification, study, and management of these complex disorders should be a cooperative effort of physician, psychologist, and educator. The use of medication must be only a part of the care of such a child but must be preceded by thorough medical examination.

If you think your child has a learning, behavioral, or emotional problem, talk to your pediatrician or family doctor, and let him guide you in affirming the existence of such disorder and its appropriate treatment.

## MEDICAL EXAMINERS

In accordance with Article 43, Section 121(12), Annotated Code of Maryland (1970) Cumulative Supplement), the Board of Medical Examiners of the State of Maryland hereby publishes notice of its intention to adopt Amendment to Regulations, as follows, on Friday, October 22, 1971, at 1:00 p.m., at the Board of Medical Examiners, 1211 Cathedral Street, 3rd Floor, Baltimore, Maryland 21201.

Amendment to Regulations of the  
Maryland State Board of Medical Examiners — I. E. Practice without a License

Copies of the proposed Amendment are available in the Office of the Board of Medical Examiners, 1211 Cathedral Street, Baltimore, Maryland 21201.

Interested persons have the opportunity of submitting data or views, orally or in writing, to the Office of the Regulations Coordinator, Room 1302, State Office Building, 301 West Preston Street, Baltimore, Maryland 21201, prior to, or at the time of, the intended action by the Board.

Upon failure to submit data or views, orally or in writing, the Amendment may be adopted upon the statement of parties present.



Pages 41-44 missing







# FIFTH ANNUAL SEMINAR ON THE MEDICAL ASPECTS OF SPORTS

Saturday, December 4, 1971

Catonsville Community College

800 South Rolling Road, Catonsville, Maryland

Chairman of Arrangements: Charles M. Henderson, MD

- |          |   |          |  |
|----------|---|----------|--|
| 8:00 AM  | Registration—Classroom Building<br>Coffee and donuts—Visit exhibits   |          | Baltimore Bullets Basketball Team  |
| 9:00 AM  | Opening Remarks<br>B. A. Barringer, President,<br>Catonsville Community College<br>John F. Schaefer, MD, President<br>Medical and Chirurgical Faculty<br>of Maryland  | 11:00 AM | Conditioning and Rehabilitation<br>of the Knee<br>Mr. William Neill, Chief of Physical<br>Therapy, Kernan Hospital   |
| 9:15 AM  | Anatomy of the Knee and its<br>Supporting Structures<br>Karl F. Mech, MD, Associate<br>Professor of Anatomy, University<br>of Maryland School of Medicine<br>Former Chief of Surgery,<br>St. Agnes Hospital | 11:45 AM | Lunch—Box lunch will be provided   |
| 10:00 AM | Acute and Chronic Problems of the<br>Knee as Related to Athletics<br>Kenneth F. Spence, MD,<br>Instructor in Orthopedics<br>University of Maryland<br>School of Medicine<br>Team Physician,                 | 1:15 PM  | Physiological Guidelines to Follow<br>to Reduce the Weight Loss Problems<br>of Wrestlers<br>Charles M. Tipton, PhD, Director,<br>Exercise Physiology Laboratory,<br>Department of Physical Education<br>and Physiology-Biophysics,<br>University of Iowa |
|          |   | 2:00 PM  | Football-Incurred Maxillo-Facial<br>Injuries<br>Christopher O'Connell, DDS   |
|          |   | 3:00 PM  | Taping Clinic<br>Mr. William Neill and trainer's staff<br>of the Baltimore Colts   |

Program is sponsored by the Medical and Chirurgical Faculty of the State of Maryland and by the Division of Health, Physical Education, and Recreation of Catonsville Community College.

Fifth Annual Seminar on the Medical Aspects of Sports, December 4, 1971

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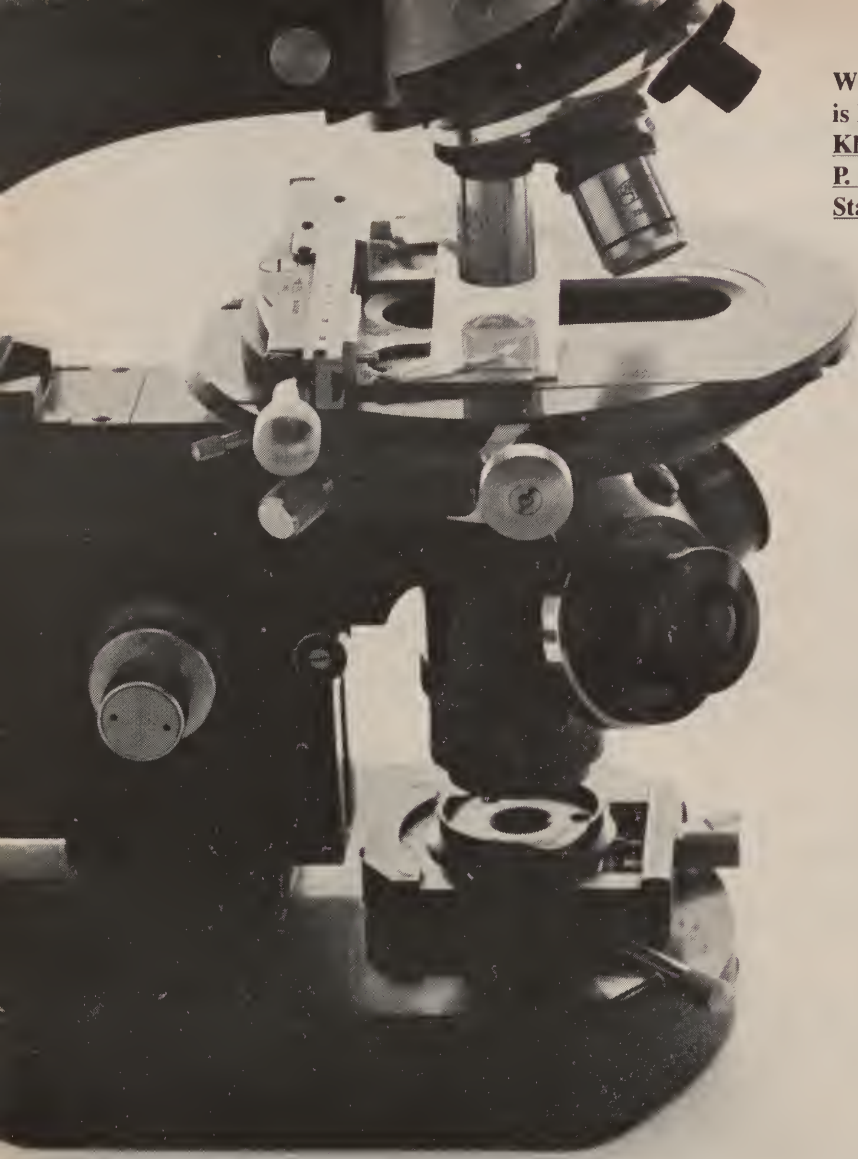
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**Indications:** Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms, (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Important Note:** *In vitro* sulfonamide sensitivity tests are not always reliable; tests must be coordinated with bacteriologic and clinical response. Aminobenzoic acid should be added to follow-up culture media for patients already taking sulfonamides.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including sulfonamides.

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

**Contraindications:** Hypersensitivity to sulfonamides, infants less than 2 months of age, pregnancy at term, and during the nursing period.

**Warnings:** Safety of sulfonamides in pregnancy has not been established. Sulfonamides will not eradicate group A streptococci. Deaths have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias associated with sulfonamide administration. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

**Precautions:** Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, ex-

foliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with the agents.

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# **ATTENTION—ALL PHYSICIANS IMPORTANT DATES**

**Wednesday, Thursday, Friday 3, 4, 5, May 1972**

## **174th Annual Meeting Medical and Chirurgical Faculty at the Baltimore Civic Center**

- **New Continuing Medical Education Experiences** for all physicians
- **Multiple Sessions for Specialties** to run concurrently
- **Plenary Session on a subject of common concern**, Chaired by  
John F. Schaefer, MD  
President
- **Round Table Luncheon** dares to be different
- **Health Evaluation Tests:** Keep Your Finger on Your Own Pulse!
- **Annual Presidential Reception and Banquet**
- **Ample Space for SCIENTIFIC and TECHNICAL EXHIBITS**
- **Excellent General Facilities and Convenient Parking**

**MARK THESE DATES NOW  
3, 4, 5, MAY 1972**

**WATCH THE JOURNAL EACH MONTH  
FOR FURTHER INFORMATION**

**John B. De Hoff, MD, Chairman  
Committee on Program and Arrangements**

**See Page 94 for Scientific Exhibits space application**



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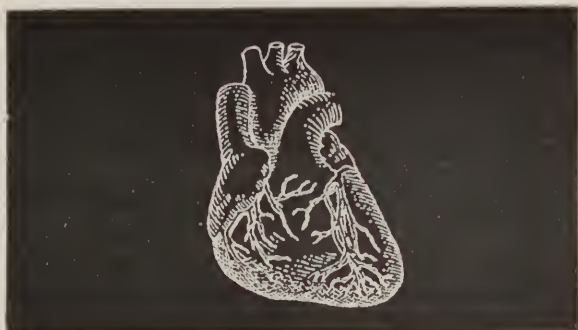


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## the heart page

# Echocardiography of the Mitral Valve

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Ultrasound in medicine provides a noninvasive means of measuring the position and movement of normal and abnormal structures inside the body. Since the early pioneering work was performed in the evaluation of mitral stenosis by echocardiography, numerous studies have confirmed the efficacy of this technique.<sup>1-6</sup> In the last few years, the scope of ultrasound in the recognition of cardiac disorders has increased considerably and it has been shown to be of value in diagnosing pericardial effusions,<sup>7</sup> congenital heart lesions,<sup>8-9</sup> and in evaluating left ventricular function.<sup>10</sup> This report describes the use of ultrasound in various disorders that affect mitral valve movement, either during systole or diastole.

Ultrasound involves the use of two basic principles: 1. The piezoelectric effect whereby electrical energy is converted to sound energy and vice versa, and 2. The refraction and reflection of sound waves that occurs as they pass across an interface. These phenomena result in the production of a characteristic echo pattern for different structures.

Most available commercial ultrasound equipment uses a transducer (0.75 inch diameter, 2.25 megahertz) with a repetition rate of 1,000 impulses/sec. Using a water-soluble gel to produce airless contact between the transducer and the patient's skin, the mitral valve can be visualized in the normal subject by placing the transducer in the third or fourth interspace, 1 to 4 cm lateral to the left sternal border.

### Normal Mitral Valve Movement

Upward deflection of the mitral valve (Figure 1) represents anterior movement of the anterior leaflet of the mitral valve (AM) and corresponds to the open position of the valve. The normal AM echo, when recorded simultaneously with the electrocardiogram (EKG), has the appearance of an "M". During diastole, the anterior leaflet of

the mitral valve moves anteriorly to the E point. The leaflet then moves posteriorly to the F point which represents diastolic semiclosure. Following atrial contraction, the valve opens and this opening movement corresponds to the A point on the ultrasound cardiographic tracing. The valve assumes the closed position at point B and moves to its most posterior position at C with the onset of ventricular ejection (Figure 1). The normal posterior leaflet movement (PM) has the exact opposite configuration, namely a "W". According to Wharton,<sup>6</sup> the third heart sound occurs 0.02 sec after the maximal opening of the mitral valve (E point).

### Clinical Applications

1. **Rheumatic Mitral Valve Disease:** Mitral stenosis is the condition which probably generated the greatest interest in ultrasound. Classically, it is characterized by loss or diminution of the A wave and marked decrease in the E-F slope. No case of mitral stenosis with a normal echo has yet been documented.<sup>1</sup> Independent studies by Gustafson,<sup>2</sup> Joyner,<sup>3</sup> Segal,<sup>4</sup> and Winters<sup>5</sup> have shown that mitral stenosis is associated with slopes less than 70 mm/sec ( $N=70-150$  mm/



sec) and that severe depression of the E-F slope below 15 mm/sec<sup>2</sup> or below 35 mm/sec<sup>5</sup> correlates with a marked decrease in mitral valve area.

Significant correlation has been demonstrated with other hemodynamic data such as pulmonary wedge pressure in patients with sinus rhythm but not in atrial fibrillation.<sup>2</sup> One must be aware that certain conditions such as aortic regurgitation can increase the E-F slope per se and mask severity, although the slope will not be normal.<sup>6</sup> Post-commissurotomy evaluation with echocardiography is useful in that all cases show improvement but do not reach normal.<sup>11</sup>

In contrast to its usefulness in mitral stenosis, echocardiographic evaluation of mitral incompetence is much less rewarding except in differentiating dominant mitral stenosis from dominant mitral insufficiency (Figure 2). Segal<sup>12</sup> was able to show an increased slope in some cases but the overlap with normals was too great.

**2. Atrial Myxoma:** Echocardiography has been particularly rewarding in the differential diagnosis of mitral stenosis from atrial myxoma where a conglomerate of echoes, posterior to the echo derived from the mitral valve, is found.<sup>13-14</sup>

**3. Idiopathic Hypertrophic Subaortic Stenosis (IHSS):** In IHSS, the most important finding is that of a systolic anterior movement of the anterior mitral valve leaflet<sup>15</sup> which relates to the narrowing of the outflow tract and the dip in the arterial pulse (Figure 2). Other less constant features are the contact of the anterior leaflet tracing with the interventricular septum during diastole<sup>16</sup> and the decrease in the E-F slope related to the decrease in left ventricular compliance with resultant increase in resistance filling during early diastole. These features are regarded as highly diagnostic for IHSS; however, to demonstrate them, provocative tests such as the Valsalva maneuver, or pharmacological methods may have to be employed.

**4. Mitral Valve Prolapse:** Patients with the syndrome of systolic click and late systolic murmur may have a characteristic echocardiographic appearance.<sup>17-18</sup> Kerber, et al,<sup>17</sup> and Dillon, et al<sup>18</sup> have recently described a change in the CD component of the echocardiogram. Normally when the posterior leaflet is visible by echocardiography, it is seen immediately adjacent but below the anterior leaflet (see Figure 1). In this syndrome, however, the two leaflets are characteristically separated during systole (see Figure 2). The most common abnormality is a check of the normal anterior movement of the anterior leaflet in middle or late systole, followed by a posterior displacement, generally in a smooth semilunar pattern (Figure 2). The posterior leaflet

is displaced posteriorly toward the left atrium during late systole.

**5. Aortic Regurgitation:** In chronic aortic regurgitation, Winsberg, et al<sup>19</sup> demonstrated fine repetitive oscillations which began at the point of maximal opening of the anterior leaflet of the mitral valve (E point) and generally terminated with ventricular systole. In Pridie's<sup>20</sup> series, those patients with an Austin-Flint murmur who did not show diastolic fluttering had premature mitral valve closure not greater than 0.05 sec before the Q-wave. On the basis of these observations, there are two explanations for the origin of the Austin-Flint murmur.<sup>20</sup>

By contrast, mitral valve closure in acute aortic insufficiency precedes the QRS by more than 0.05 sec and may even precede the P wave (Figure 2).<sup>20</sup> In addition, delayed diastolic opening together with prolongation of systole leads to gross curtailment of diastolic mitral valve opening. This is due to the development of a high left ventricular pressure in diastole that quickly exceeds the left atrial pressure and causes premature mitral valve closure.

At the present time, ultrasound has a definite role to play in evaluating patients with mitral disease. There is little doubt that in the future, the technique will be used routinely to investigate structural and functional abnormalities of the heart.

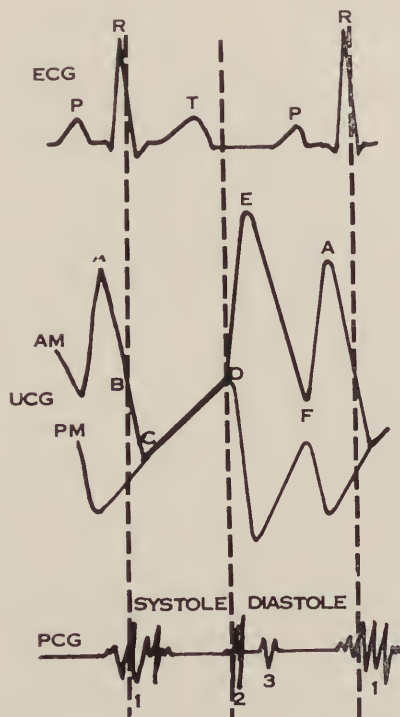
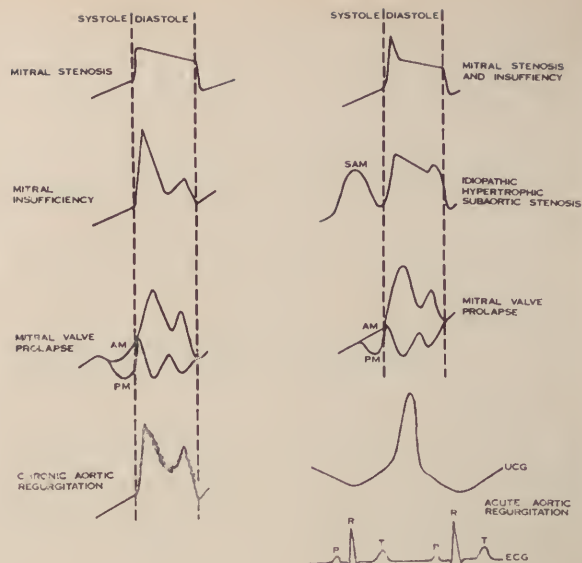


Figure 1: A schematic representation of the ultrasound cardiographic tracing of mitral movement, showing its relation to the electrocardiogram and phonocardiogram.



Figure 2: Schematic presentation of abnormal mitral valve motions.



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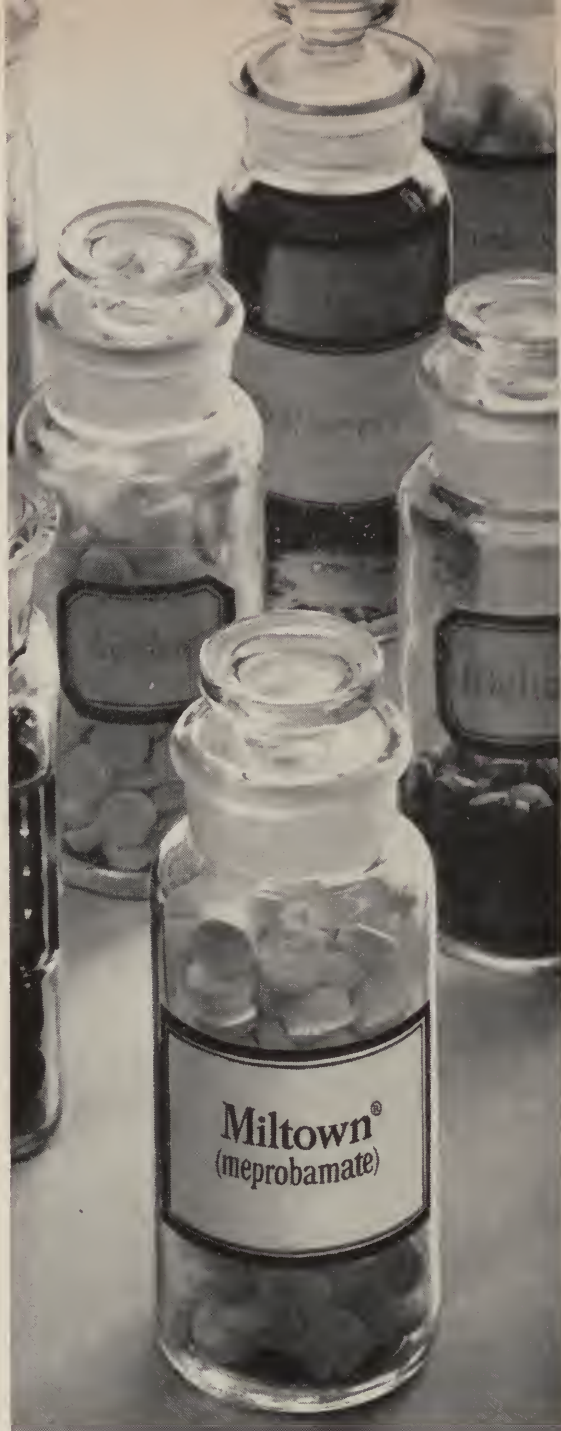
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## rehabilitation medicine

# Ambulation Aids

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In the 20th century great emphasis is placed on a perfect physique and the agility of youth. The elderly individual with failing vision, diminished proprioception, and poor balance would benefit greatly from the support of a cane, but he hesitates to admit a failing image and is willing to sacrifice safety for vanity.

Dr. Blount,<sup>1</sup> in an article published in 1956 entitled "Don't Throw Away the Cane," has urged the use of a cane for support. One could only wish that the style setters of today would again make the cane a part of fashionable attire. Perhaps then, those that need it would compromise vanity for sanity.

In the presence of pathological conditions, the physician frequently faces the problem of determining the type of ambulation aid most efficient for a specific patient.

### The Purpose of Prescribing an Ambulation Aid

Aids are usually required for:

1. Sensing (a cane for the blind)
2. Balancing
3. Support
4. Reducing stress on an involved extremity

For these purposes we prescribe various forms of canes, crutches, and walkers. It is the physician's responsibility to evaluate the patient's needs to determine the type of equipment and to prescribe the adequate aid and appropriate gait pattern. The efficient use of a supportive aid will

depend on the patient's physical and mental abilities and on his desire to use it effectively.<sup>2</sup> No ambulation aid should be prescribed without adequate training in its use. Training should be provided by a knowledgeable individual—a therapist, nurse, or physician. Also, members of the family should be instructed if they are to supervise and assist the patient with ambulation.

### Choosing An Ambulation Aid

The following factors are important to consider in choosing an ambulation aid:

1. The patient's general physical and mental condition
2. The presenting pathological condition requiring support
3. The strength of the upper extremities
4. The patient's balance
5. The environmental needs

1. A severely debilitated individual may not be able to support his weight on the upper extremities if he is physically debilitated or mentally incompetent and cannot learn how to use the assistive device.

2. The knowledge of underlying pathology is essential in choosing an appropriate ambulation aid. For example, a rheumatoid arthritic individual with very painful swollen wrists and hands cannot use a regular crutch or cane, but can very satisfactorily use a platform crutch (Figure 1), which permits maximum weight bearing on the extensor surface of the forearm.

3. When there is a need to eliminate weight bearing on one or even both lower extremities, such as an osteoarthritic hip, fractures of the lower extremities, amputations, or paralysis, adequate strength of the upper extremities is critical, since partial or total weight has to be supported on the upper extremities.





Figure 1: Platform Crutch



Figure 3: 1) adjustable forearm (Lofstrand) crutch, 2) forearm crutch with 3 pronged tip, equipped with round crutch tips, 3) adjustable auxiliary crutch with a wide suction tip, 4) adjustable aluminum cane with wide suction tip, 5) a four pronged or crab cane, equipped with rounded tips, 6) another type of quad-ripped cane



Figure 2: Crutch Tips—suction and rounded





Figure 4: Hemiplegic using a forearm crutch



Figure 5: Pick-up Walker (Walkerette)



Figure 6: Use of stair climbing walker in ascending stairs



Figure 7: Use of stair climbing walker in descending stairs



## Canes

Canes are prescribed to improve balance. In hip disease, canes reduce weight-bearing stress by reducing the great force of the hip abductors and body weight. A cane provides limited support. They are used for safety and balance and should be equipped with 1½ to 2 inch rubber suction tips (Figure 2). Rounded rubber tips frequently seen on canes should be substituted with a suction tip in order to avoid sliding, which causes the patient to lose balance. The proper length is determined by measuring from the patient's greater trochanter to the floor, with the elbow flexed 15 to 20 degrees. The cane should usually be held in the hand opposite to the involved lower extremity. There are a few exceptions (amputees, deformities, unusually marked dominance, etc).

**Reasons for Using the Cane on the Opposite Side:** 1. It simulates physiological gait pattern where the opposite arm swings with the swing phase of the lower extremity; 2. It provides a wider base and improves balance; 3. It also supports the involved extremity during the shift of the center of gravity.

A quadriped cane, with its broad base and four prongs (Figure 3), was devised to provide better balance, and for that reason, is frequently prescribed for hemiplegic patients. However, it has some serious disadvantages. The long prongs catch on furniture or rugs, and the patient trips easily. The canes are heavy and clumsy, and cannot be used for stair climbing. They are, however, definitely indicated for patients with athetosis or ataxia. They should be provided with adequate wide suction tips, and frequently additional lead weights are added for greater stability.

A hemiplegic patient is poorly coordinated and has weak hip stabilizing muscles on the hemiparetic side. This causes the trunk to lean to one side when the weight is on the hemiparetic leg, throwing the patient off balance. He also has impairment of perception of verticality.<sup>6</sup> The patient should first be trained in parallel bars. Once he is able to achieve a good balance and has learned to shift his body weight and feels secure, he can then progress to ambulation with a Lofstrand or forearm crutch (Figure 4), which can efficiently support 40% to 50% of the body weight. The crutch is stable by virtue of a two-point contact with the upper extremity (forearm and hand). With increased endurance and efficiency in ambulation, the patient can progress to a cane.

Patients with degenerative or osteoarthritis of the weight bearing joints, such as knees and hips,

present a different mechanical problem in ambulation.<sup>3</sup> The disease is progressively destructive because of constant stress during ambulation. The stress on the hips is not only provided by the force of the body weight, but also by the pull of the hip abductors which provide a counter-force necessary to keep the pelvis level. This not only adds to the stress and contributes to the further pathology of the joint, but also contributes to a great deal of discomfort. An underarm or Lofstrand (forearm) crutch will give 40% to 50% of support to an extremity.<sup>2</sup> Canes are also useful here. Bilateral crutches decrease the total force and give about 80% of support. In osteoarthritis, the patient can utilize partial weight bearing, and a forearm crutch or a pair of crutches is the most satisfactory means of supporting these joints in ambulation.

## Crutches

A Lofstrand (forearm) crutch (Figure 3) is lightweight. It is easily adjustable to the height of the patient. The cuff usually encloses the forearm so that the patient can rest on it and release the hand without dropping the crutch to free the hand for some other activity.

In measuring for Lofstrand crutches, handgrip height is measured from the outermost border of the shoe at toe level, two inches out to the side, with patient's hand clenched on handgrip and elbow flexed at 20 to 30 degrees. The forearm cuff should be 1 inch below the elbow when the handgrip is clenched by the hand.

Underarm or axillary crutches are measured from 2 inches (three finger breadths) below the axilla to the heel, plus 6 inches.<sup>4</sup> They are very effective in reducing maximum weight bearing on the involved extremity. They are usually made of wood, are cheap and lightweight (Figure 3). However, they do require good strength in the upper extremities. In dealing with fractures of the lower extremities a need arises to eliminate total weight bearing on that extremity. Axillary crutches are the most efficient means of giving such support. The patient must be instructed in the correct manner of ambulation, that is, a 3-point gait—two crutches and one leg—using a swing-through gait most of the time. He must also be instructed not to lean on the crutches when standing, since the pressure in the axillary space may produce a partial compression of the brachial plexus, resulting in crutch paralysis. Rubber axillary pads do not prevent crutch paralysis. When using any type of crutches, the patient must be instructed how to ascend and descend steps and to ambulate on carpet, grass, ramps, and curbs.



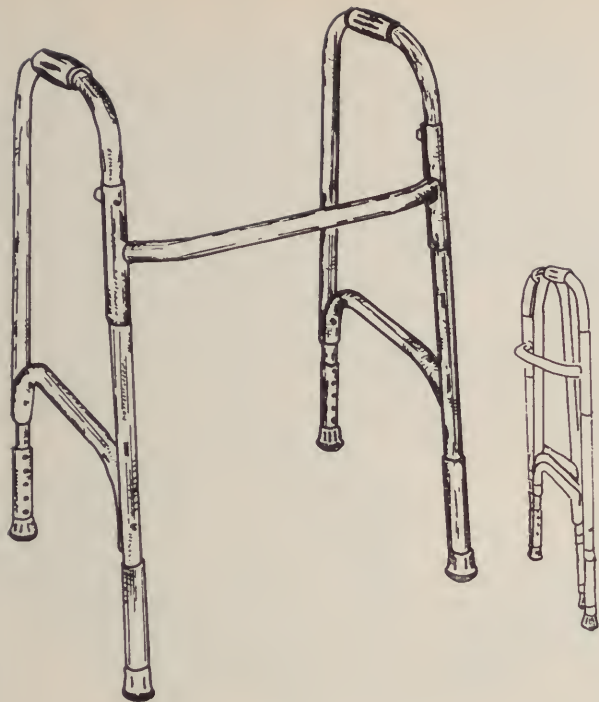


Figure 8: Folding type walker

### Walkers

For elderly, debilitated, or poorly balanced individuals, crutches are not the best aid for ambulation. For these we use a pick-up walker, which provides a broad base, 4-legged support and aids in balance.

There are different types of walkers (Figure 4) on the market, but the simplest pick-up walker (walkerette) is the best yet. It should be of adjustable height, lightweight and provided with two-inch suction cup tips. It is usually inexpensive and provides good stability. It can be stationary or a folding type (for storage). Walkers equipped with casters are not recommended, since most of the time the patient glides rather than walks, and it does not provide stability. They are heavy, clumsy and expensive. If the patient is unable to stand up straight, the walker will roll in the direction toward which the patient leans, and the patient loses his balance. The pick-up walker or walkerette cannot be used when climbing stairs. If it is important for the patient to learn to negotiate steps, and he cannot use crutches, a stair climbing walker can be provided. (Figure 5)

An elderly amputee with poor cardiac reserve, poor balance, and poor muscle strength is best trained to ambulate with the aid of a walker. Axillary crutch walking places a heavier work

load on the heart. In amputees, the energy consumption is higher when walking with crutches than with an artificial limb.<sup>5</sup>

In the presence of injury or catastrophic disease, such as strokes, patients are quite willing to accept an aid for ambulation, but it takes the physician's decisive recommendation and his own conviction to influence a patient with arthritis or other debilitating disease to use an ambulation aid.

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**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

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**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly. **Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

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# Urban Health Challenge: Survey of Physician Manpower In Metropolitan Baltimore

ERIC M. FINE, MD  
Department of Pediatrics  
University of Maryland Hospital  
Baltimore

Recent studies of the Baltimore Standard Metropolitan Statistical Area seem to indicate a declining urban population accompanied by a growing suburban population and decreasing numbers of urban based primary-care physicians over the past 40 years. What, then, is the current pattern of health care in this region, and what is the present distribution of primary-care physician manpower? This survey will attempt to clarify these questions for the Baltimore Standard Metropolitan Statistical Area.

One half of the entire population of the state of Maryland lives in the Baltimore Standard Metropolitan Statistical Area (Figure 1). In 1967, the Baltimore City Health Department undertook a detailed study of physician manpower throughout this area and, in part, concluded "... how unplanned the distribution of physicians was by specialty and location."<sup>1</sup> In Baltimore city, De Hoff substantiated the magnitude of the health-care problem by surveying the distribution of primary-care physicians from 1929 to 1969 and revealing "... an absolute loss of approximately 428 generalists ..." over the period.<sup>2</sup> Tayback has characterized the population of Baltimore city as declining at a rate of 0.5% annually. He further described the rapidly changing composition as a "consequence of exceptional net out-migration of the middle income white population." The remaining white population accounts for little natural increase, while the black population increases at the rate of 1.5% annually.<sup>3</sup>

## Method

Employing the method of De Hoff,<sup>2</sup> information on primary practitioners in the Standard Metropolitan Area was obtained from two sources: the 1967 data of McMillan's Physician Manpower Survey for Baltimore city<sup>1</sup> and the 1970 Baltimore City Health Department Physi-

cians Referral Listing.<sup>4</sup> Detailed information prior to 1968 regarding physician manpower in specific areas of Baltimore city was not available as such from the health department; therefore, by applying De Hoff's technique, the 1965 and 1969 American Medical Association Directories<sup>5-6</sup> were analyzed as sources of full-time, practicing physicians by location. City postal zones, in this case, were selected for rapid, convenient address classification-coding and because they have not been altered during the periods under investigation as have the census tracts, as De Hoff points out.<sup>2</sup> Statistical significance was derived through use of Chi-Square Analysis and the multiple range test of Duncan.<sup>7</sup>

## Results

Comparison of the numbers of full-time practitioners by location in 1967 and 1970 reveals substantial increases in manpower for Baltimore city and the counties. In fact, the data in Table 1 show that during the three-year period from 1967 to 1970, Baltimore city and the five adjacent counties all experienced absolute increases in numbers of physicians. These increases are verified in Table 1 by applying the respective physician-population ratios, expressed as primary-care physicians per 100,000 population. Simple calculations demonstrate that the three suburban areas



Postal Zone	Primary Physicians 1965	Physicians 1969	Time-Change Number %	
Net Gains (Critical Value more than 2.18)*				
4	18	72	+54	+300
5	40	57	+17	+ 42.5
7	36	39	+ 3	+ 8.3
8	22	34	+12	+ 54.5
9	17	32	+25	+147
10	45	84	+39	+ 86.7
12	95	112	+17	+ 17.8
15	84	107	+23	+ 27.3
18	116	121	+ 5	+ 4.3
24	32	42	+10	+ 31.2
27	15	19	+ 4	+ 26.7
28	34	51	+17	+ 50
29	51	81	+30	+ 58.8
34	20	29	+ 9	+ 45

<b>Insignificant Change (Critical Value less than 2.18)</b>				
11	16	16	0	0
16	22	24	+2	+9.1
19	4	5	+1	+25
21	10	11	+1	+10
22	11	11	0	0
25	15	15	0	0
26	2	2	0	0
31	18	20	+2	+11.1
36	2	2	0	0

<b>Net Losses (Critical Value more than 2.18)*</b>				
1	230	206	-24	-10.5
2	296	259	-35	-11.8
6	27	24	-3	-11.1
13	25	22	-3	-12
14	22	19	-3	-13.6
17	122	63	-59	-48.3
20	6	3	-3	-50
23	27	23	-4	-14.8
30	21	12	-9	-42.8

\*Significant at the  $p < 0.05$  level

Table 1: Location and number of full time practicing physicians, Baltimore S.M.S.A., 1967-1970

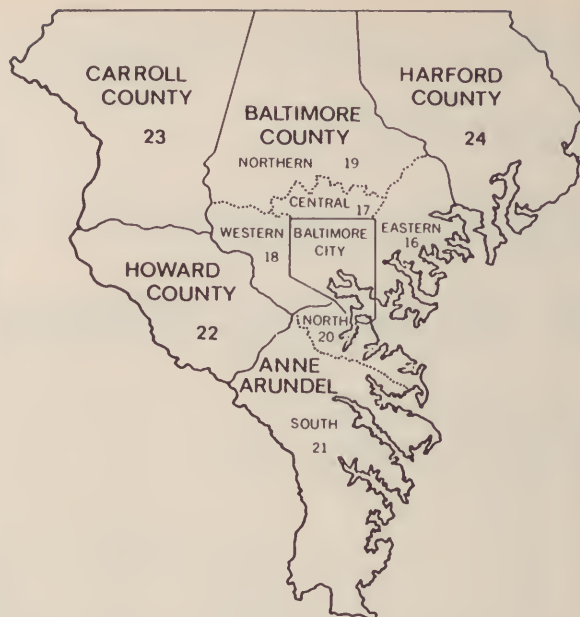


Figure 1: Baltimore S.M.S.A. County Divisions

of Baltimore County, Anne Arundel County, and Howard County achieved physician increases of 41%, 59%, and 61% respectively; while the number of physicians in the rural counties of Harford and Carroll only increased by 21% and 7.5% respectively. Baltimore city, however, had the second lowest increase of practitioners, comprising only 18% over the three-year period.

Analysis of the practitioners in metropolitan Baltimore by postal zone of declared office address in 1965 and 1969 (Table 2) reveals 14 distinct postal zones with statistically significant net increases in physicians over the four-year period. These increases range from 4% in Waverly (Zone 18) to 300% in Towson (Zone 4). Ten postal

Table 2: Total gains and losses in primary-care physicians by postal zone location, Baltimore Metropolitan Area, 1965-1969

	1967		1970		1967-70
	Physicians	MD per 100,000*	Physicians	MD per 100,000**	Percent Increase
Baltimore City	1457	159	1710	188	18
<b>COUNTIES</b>					
Anne Arundel	120	44	209	70	59
Baltimore	390	68	601	96	41
Carroll	49	80	60	86	7.5
Harford	53	52	73	63	21
Howard	16	31	31	50	61
<b>TOTAL</b>	<b>2085</b>		<b>2684</b>		

\* State of Maryland 1966 Population Estimates

\*\*1970 U.S. Census

Source: Baltimore City Health Department



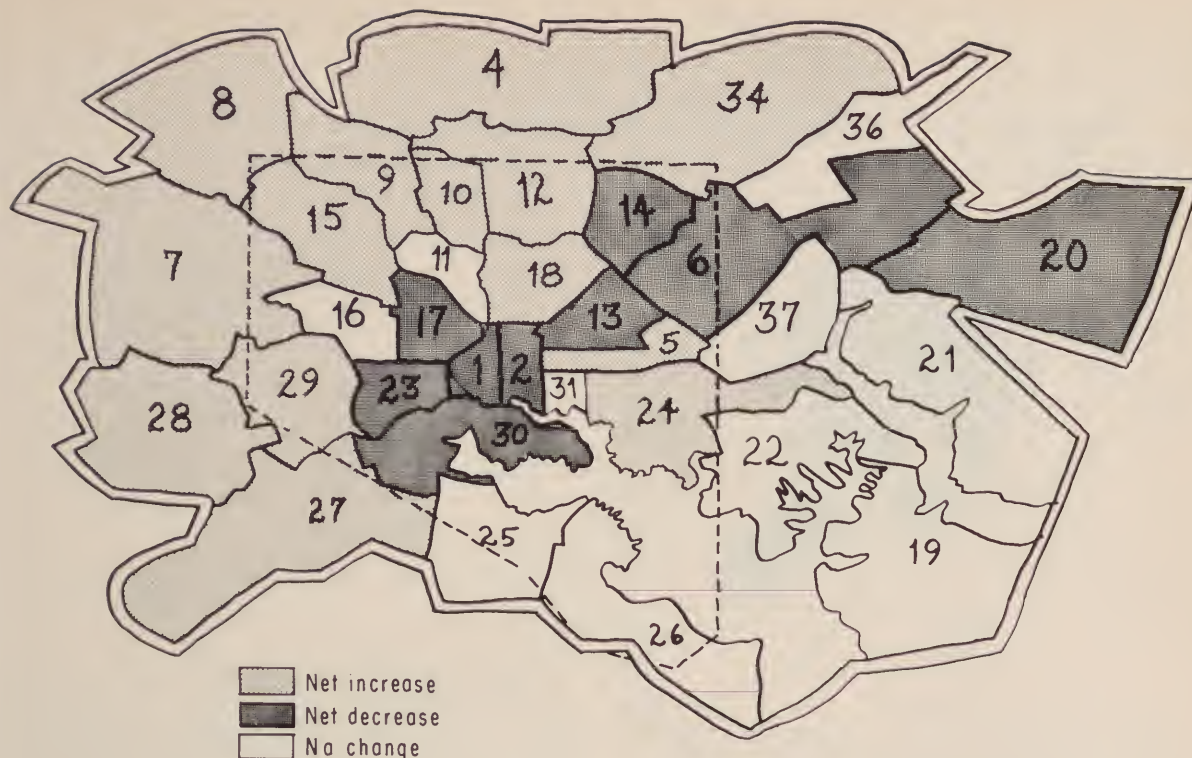


Figure 2: Net migration of primary-care physicians by office postal zone, Baltimore Metropolitan Area, 1965-1969

zones, primarily in the eastern and southeastern portions of the city, including Essex, Dundalk, Sparrows Point, Rosedale, Brooklyn, and Curtis Bay, show no statistically significant changes over the same period. However, eight postal zones in the central and northeastern city plus Middle River (Zone 20) demonstrate statistically significant net losses in practitioners, ranging from 10% downtown (Zone 1) to 48% in Lower Druid (Zone 17).

The distribution of total losses and gains is shown in Figure 2. Average total gains for all increasing zones were 41.8%, while average total losses were 18.5% of the practitioners from 1965 to 1969. Statistical significance was present at the 0.05 level by the Chi-Square Analysis of two variables of change. The least significant difference was derived from *Duncan's Multiple Range Test*<sup>7</sup> for which the Critical Value for significance at the 0.05 level was 2.18 physicians.

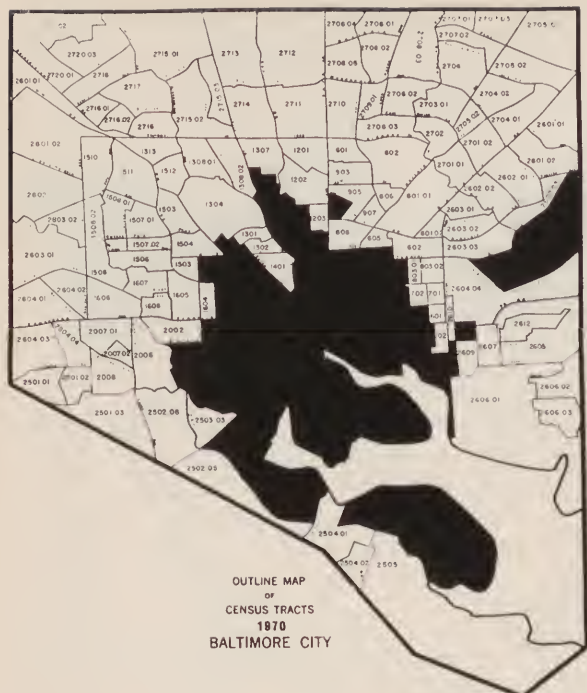
#### Discussion

In 1942, Mountin and Pennell first described the phenomenon of declining physician-population ratios among low income metropolitan areas based on observations during the period from 1923 to 1938.<sup>8</sup> Terris and Monk restated these findings in 1956 for three metropolitan areas of upstate New York (1940 to 1950).<sup>9</sup>

This study of metropolitan Baltimore and the surrounding area, in view of these previous efforts, presents several interesting observations. Foremost, a significant decline in available primary-care medical manpower is documented over a three- to five-year period as compared with ten- and fifteen-year periods described by previous investigations. Secondly, recent census reports<sup>10</sup> confirm the increasing suburban population growth; and practicing physicians are increasing in most of these county areas at a faster rate than that of the overall population. This is beneficial to future development of suburban and semirural areas; and this is probably expected because of the net outmigration from the city of the white middle class population previously described by Tayback.

Yet, cursory inspection of Figure 2 reveals that the modest increase in the number of Baltimore city practitioners occurred primarily in suburban regions of the city, while the so-called Inner City experienced a definite net loss. Tayback attributes this pattern "... to attrition from death or retirement without replacement and to departure of practicing physicians to surrounding suburban areas."<sup>3</sup> In addition, most young physicians are apparently establishing new offices in these same peripheral and suburban areas.





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Figure 3: Population distribution of lower two socioeconomic fifths by median rental, Baltimore city

Further evaluation of Baltimore city by census tracts reveals (Figure 3) the precise pattern described by Mountin and Pennell and confirmed by Terris and Monk. The shaded area of Figure 3 identifies the lowest two socioeconomic fifths, comprising 40% of the city population, as measured by Median Rentals ranging from \$40 to \$70 a month.<sup>11</sup> The striking similarity between the geographical distributions of urban poor in Figure 3 and physician manpower losses in Figure 2 provides an obvious explanation for the problems of city health planners and providers. In addition, the exodus of Baltimore community hospitals from the city to the suburbs over the past five years is well known. The obvious total result of all these effects is to diminish physician and hospital services to the lowest socioeconomic segment of the population.

Figure 4 demonstrates some of the implications of these trends. The figure compares rates of population growth, hospital admissions, outpatient department visits, and emergency department visits on a semilog scale from 1960 to 1968 in the Standard Metropolitan Area. The remarkable fact is that from 1965 to 1968, population and hospital admissions increased slightly while outpatient department visits remained unchanged, but emergency department visits in-

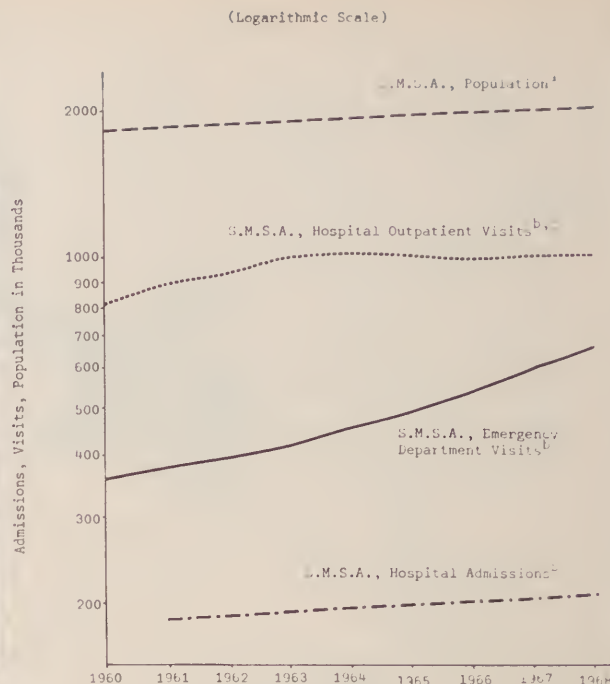


Figure 4: Annual visits to emergency departments compared to population, hospital outpatient visits, and hospital admissions, Baltimore S.M.S.A., 1960-1968<sup>12</sup>

creased by 200,000 in three years.<sup>12</sup> Thus, the urban emergency department has become the substitute for a primary practitioner.

Webb supports this contention by analyzing the types of emergency visits in Table 3. It is readily noted that over 50% of 22,105 visits to emergency departments of large city hospitals were nonurgent. Further, almost 57% of pediatric emergency visits were for nonurgent conditions as well. Webb also demonstrated a high degree of correlation between the low socioeconomic level of patients and increased emergency department utilization for nonurgent conditions. Strikingly, it was noted that 52% of patients with nonurgent conditions declared they had no regular physician.<sup>12</sup> Thus, the exodus of practitioners and hospitals to the suburbs, the increasing utilization of remaining emergency departments by urban poor, and the maldistribution of increasing physician manpower all characterize the proven current health situation in the Baltimore Standard Metropolitan Statistical Area.

This survey of physician manpower has demonstrated significant trends in net physician migration. In fact, observing these trends nationally, Ginzberg has observed that "... physicians have considerable discretion as to where they want



Table 3: Urgency by hospital strata for emergency department patients, Baltimore S.M. S.A., November 1938<sup>12</sup>

Urgency	% Emergency Department Patients, Hospital Strata <sup>a</sup>					
	City >400 Beds N=22,105	Pediatric N= 4,787	City <400 Beds N=11,705	Suburban N= 6,571	Outlying N= 5,952	Total N=51,125
Emergent	4.6 ±0.1	1.4 ±0.0	9.8 ±0.2	7.4 ±0.2	7.9 ±0.2	6.2 ±0.1
Urgent	32.2 ±0.5	16.8 ±0.6	42.4 ±1.0	53.8 ±1.7	48.1 ±1.6	37.7 ±0.4
Nonurgent	51.1 ±0.9	56.7 ±2.0	43.6 ±1.0	33.5 ±1.0	34.8 ±1.1	45.8 ±0.5
Scheduled Procedure	7.2 ±0.1	23.7 ±0.8	1.9 ±0.0	3.9 ±0.1	7.7 ±0.2	7.2 ±0.1
D.O.A.	0.3 ±0.0	-	0.5 ±0.0	0.4 ±0.0	0.8 ±0.0	0.4 ±0.0
Unspecified	4.6 ±0.1	1.4 ±0.0	1.8 ±0.0	1.1 ±0.0	0.7 ±0.0	2.7 ±0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

<sup>a</sup>±S.E. of the percentage. S.E. 0.0 is < 0.05.

to practice, and that, generally, is not among the urban or rural poor . . ."<sup>13</sup> The findings of this survey and that of Terris and Monk tend to support this indictment of the medical ethic. For physicians to passively accept these findings or to commit themselves to solving the obvious health needs of city and state may very well determine the entire future of medical practice. This is the challenge for the physicians of the state of Maryland and, indeed, the nation.

### Summary

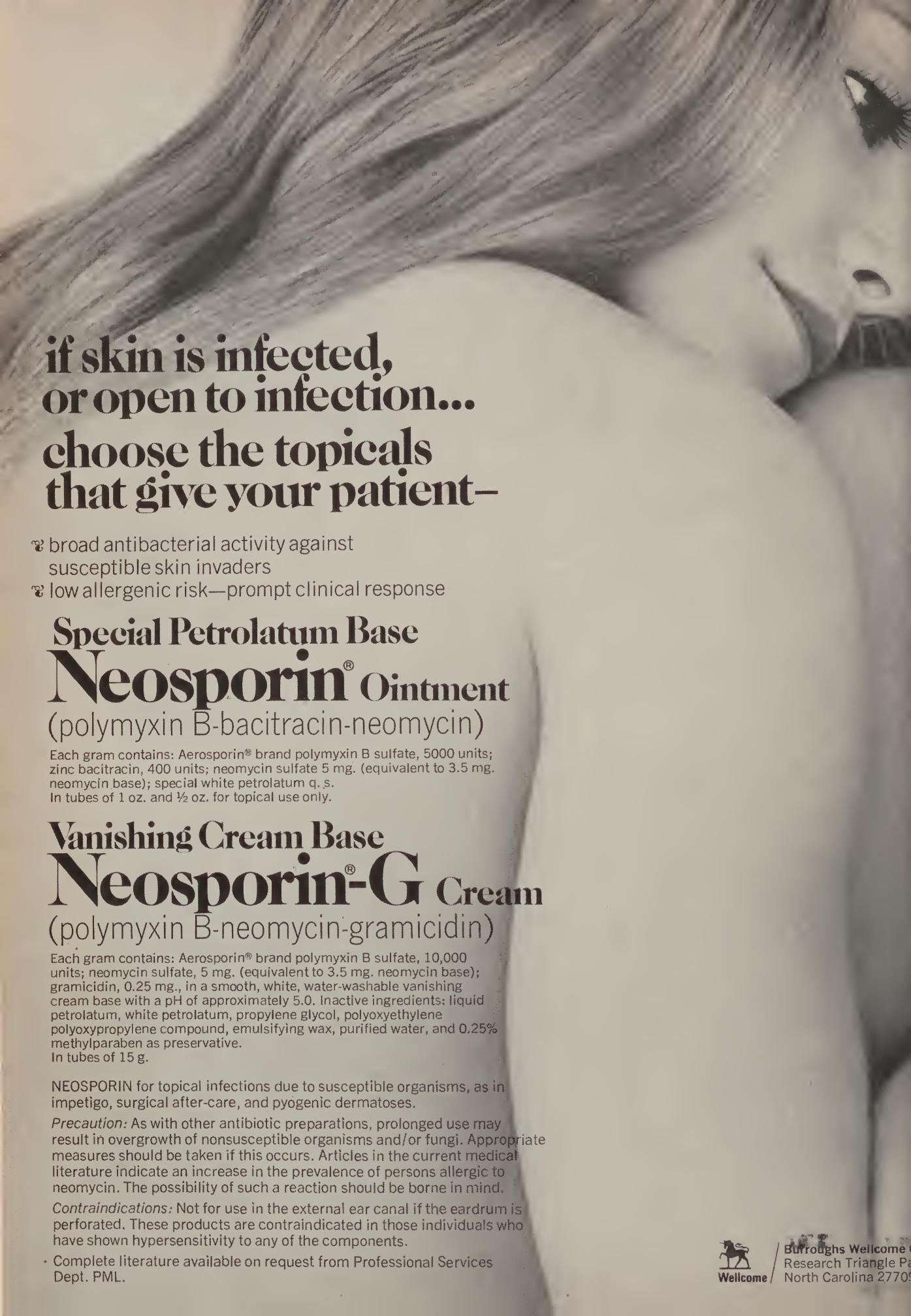
A five-year statistical survey of available physician manpower in metropolitan Baltimore is carried out using three comprehensive sources. Preliminary findings confirm the efflux of physicians from central and northeast Baltimore into suburban areas and surrounding counties of the Standard Metropolitan Statistical Area. It is shown that while Baltimore city experienced an overall 18% net increase in practicing physicians from 1967 to 1970, eight central zones of the city combined lost up to 18.5% of physician manpower. Concurrently, 14 zones in suburban areas demonstrated a 42% increase in practicing physicians.

Major factors influencing practitioner migration appear to be: migration of the middle-class population, attrition of older practitioners, and establishment of new practices outside the Inner City. Movement of established practitioners appears to play a minor role in the net efflux. Ramifications of the physician exodus are felt in escalating emergency room visits to the local hospitals for nonurgent conditions.

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# A Psychiatric Syndrome In Women Evaluated For An Unwanted Pregnancy

DONALD A. KELLOGG, MD

Active Staff, Suburban Hospital

Bethesda, Md.

Executive Committee, Suburban Maryland Chapter

Washington Psychiatric Society

A woman's desire for an abortion is her recognition that the pregnancy is the end result of a complex emotional conflict related to unsatisfactory relationships to men, her experience of intimacy in the family structure, her status on the dependency-independency axis, her self-image, and her knowledge and anxiety about sexual physiology. Most of the patients evaluated suffered from an unsatisfactory relationship to their fathers and had conflicts in many other areas of their lives. Resolution of the conflict by psychotherapy is, at best, difficult. Moreover, the economic status of this population prohibited long-term psychotherapy. Any physician seeing such a patient should be aware of the elements of this syndrome, for early recognition of the psychological problem may at least alert the patient to the problem, and thereby alleviate considerable future suffering.

This paper describes a syndrome seen in women consulting a private psychiatrist in Maryland for relief from an unwanted pregnancy. Such a woman is, ipso facto, suffering from a psychosomatic illness; the physical manifestation is the pregnancy. The data reported are derived from the unselected totality of the population referred to the author for examination between November 1969 and May 1970 (43 patients). The findings indicate that women seeking abortion in this series have characteristic mental conflicts. It is important that any physician examining such a woman be aware of these conflicts, for they bear fundamentally upon the management of the physical manifestations, and are guidelines to be followed in assessing the relief of the emotional manifestations which may persist beyond the termination of the pregnancy.

## Methods

Referrals were made by several specialists in obstetrics and gynecology. Patients were usually interviewed for 50 to 100 minutes. In general, the interview was a psychiatric evaluation which involved taking a history relevant to the circumstances surrounding the pregnancy and the patient's stated reason for wishing abortion, a family, social, and past medical history, and a mental status examination. In the case of minors (patients under age 18), the parents were interviewed with the patient, for this frequently revealed certain relevant problems in the family constellation.

In addition, patients were given a standard Minnesota Multiphasic Personality Inventory (MMPI) using Form R (hard-backed booklet).



**Table 1:**  
**Population Characteristics of Patients with PND.**

Age	Marital Status	Education	Occupation	Religion	Position		Psych. Code
					In Total	Sibship	
14	S	H-1	Student	C	3/4		CD
15	S	H-1	Student	P	1/8		C
15	S	H-1	Student	P	3/4		C
17	S	H-3	Student	P	2/5		B <sub>1</sub> CD
17	S	H-3	Student	P	1/2		CD
17	S	H-3	Student	N	4/4	A <sub>1</sub>	CD
18	S	C-1	Student	C	2/2		CD
18	S	H-2	Secretary	C	3/3		CD
18	S	H-4	Student	P	3/4		CD
19	Sep.	H-4	Secretary	P	3/3	A <sub>1</sub>	CD
19	M	C-2	Student	P	3/4		CD
19	S	C-2	Student	P	2/4		C
19	S	C-2	Student	P	2/5		CD
19	S	C-1	Rec. Clerk	C	1/3		CD
19	S	C-2	Student	P	3/4		CD
21	S	C-4	Student	J	2/4		CD
21	S	C-4	Student	P	1/2		C
21	S	H-4	Clerk	P	2/3		C
22	S	C-4	Teacher	P	1/2		CD
22	D	H-4	Splicer	P	4/4	A <sub>12</sub>	CD
22	M	H-3	Bkkep.	P	4/4	A <sub>1</sub>	CD
22	M	H-4	Un-Em.	P	1/3	A <sub>1</sub>	CD
22	S	C-1	Secretary	P	1/5	B <sub>1</sub>	CD
22	S	C-1	Secretary	P	3/3	A <sub>1</sub>	CD
23	S	H-4	Typist	J	2/3		CD
23	S	C-4	Chemist	P	2/2	A <sub>2</sub>	CD
23	D	H-4	Secretary	P	2/4		CD
24	M	H-4	Housewife	P	1/1		CD
24	S	C-1	Un-Em.	P	4/4	A <sub>12</sub>	CD
25	S	C-4	Student	P	1/2		CD
25	D	C-4	Housewife	P	1/1	A <sub>1</sub>	CD
26	M	C-4	Housewife	C	1/2		CD
26	S	C-4	Teacher	J	3/4		D
27	M	H-4	Housewife	P	1/4		CD
28	M	C-3	Housewife	C	3/3	A <sub>1</sub>	C
31	M	H-4	Housewife	P	1/2		C
32	S	C-2	Secretary	P	3/3		C
32	M	C-1	Housewife	P	1/2		C
33	S	H-1	Domestic	P	4/9		CD
34	M	H-4	Housewife	P	1/1		CD
34	M	H-4	Housewife	C	11/11		C
34	M	C-2	Housewife	C	4/4		CD
39	M	C-4	Housewife	P	4/4		CD

S—single; M—married; D—divorced; H—high school; C—college; C—Catholic; P—Protestant; J—Jewish; N—none. Psychiatric Code: A<sub>1</sub>—absent father; A<sub>2</sub>—absent mother; B<sub>1</sub>—stepfather; B<sub>2</sub>—stepmother; C—could not talk personally with father (stepfather); D—could not talk personally with mother (stepmother)

These were hand scored by key and rechecked at a later date.

## Results

**Population Characteristics:** Table 1 shows the patient's age, marital status, education, occupation, religion, referring physician, position in the sibship, and some psychological characteristics relative to the patient's memories, impressions, and experience of her parents. The age range was 14 to 39. Thirty (70%) of the 43 patients were between 17 and 26. The mean age of the population was 23.5; the median 22; and the two modes 19 and 22.

Twenty-seven or 63% were single. About half were in high school or had completed a high school education. Fifty-five percent were in college, had college experience short of a degree, or had a college degree. Thirty-five percent (15) were students, another 23% secretaries, clerks or domestics; and three had occupations above the college level. Twenty-six percent were housewives. Seventy-two percent were Protestant, 19% were Catholic, and 7% Jewish. About half of the referrals came from one physician, one quarter from another, and the remainder were divided between two other physicians.

From the total population, the most frequent patient was a first child (15 of 43) and, on the basis of family size, the most frequent patient was a first child from a family of two (7 of 9).

## Clinical Impressions

The single most outstanding clinical impression was the difficulty these women had in relationships with men and the expression of this difficulty through the intimacy of the sexual relationship with the boyfriend. This difficulty took a variety of forms. Perhaps the most frequent was the patient's experience of father as hostile, aloof, authoritarian, not infrequently alcoholic, physically violent, and demigod-like. As one patient put it, "Father never said anything; he just gave you a bust across the head." Another said: "I never knew whether I was going to get hugged or get killed, so it is safer to just go along instead of getting into a fight."

It cannot be emphasized too strongly how frequently this impression dominated the clinical picture. Consequently, these women felt helpless in relationships with men. They could not trust them; they could not talk with them; they were torn between needing them and wishing to be free of them. Several women said, "I finally decided to trust a man and look what happened." Others said, "If I didn't have intercourse with him, he would leave me." Several women had



intercourse which resulted in the pregnancy just prior to the boyfriend's departure overseas. Others had been in love, then found the relationship was not working and had broken it up, then returned for a second experience which resulted in the pregnancy.

Thus, there was a link of the experience of sexual intercourse with the threat of the loss of the boyfriend. In some cases, this was developed to the point where the patient had actually wondered or dreamed of becoming pregnant by the boyfriend and of his response to it. These patients felt that this response would finally determine whether he was trustworthy and responsible and really loved her. Many women reported that the relationship seemed smooth at first, but with the intimacy of intercourse and the pregnancy came the realization that it was not what they had expected. They appeared mystified as to how this could have occurred.

### Some Cases

In some cases the woman openly acknowledged that her boyfriend was a father surrogate; that he was the result of her search for a father. This was particularly true in those cases where father had actually died or left or had never been there. Several women said they were looking for men who could dominate them, but what they found was a man who belittled them, used them, and left them. This woman was frequently the first child in a family. One patient said she had had a good relationship with her father until her younger brother was born at which time she was supplanted by him. This latter problem, sibling rivalry, might account for the high frequency in this series of third and fourth children in families of four (13 of 16).

Another experience with the father was that of an overindulgent, permissive, superficial, and all-giving person. In many of these cases, the patient did not reveal her dilemma to her parents—especially father—for this would destroy her image (in her own as well as in father's eyes) of the perfect little girl. These women were frequently prudish, saw sex as something dirty, made tentative moves to leave the family structure, but could not find a man who met their expectations on the basis of their experience of father. One might describe them as hysterical personalities. They not infrequently were angry at physicians in general. For instance, one patient became pregnant after she stopped taking contraceptive pills because she was angry at the obstetrician-gynecologist for suggesting that she have a pelvic examination.

### Misinformation

Many women suffered from sexual misinformation and anxiety. For instance, many said that they never knew about contraception, never liked it, never thought they would have to resort to it, and engaged in impulsive intercourse ("It just happened at a party one night."). Not infrequently this was their first experience at intercourse. Sometimes this was a woman who had dated little, and had always been considered a "cold popsicle" who was attempting to break out of that image.

The patient frequently had a problem with her mother, which supplemented that with the father. Thus, she was unable to discuss sexual matters with her mother, saw that her mother was unable to establish a satisfactory marital relationship, and ruefully noted that she "runs the household."

In the teenage group, these problems took on unique characteristics. The patient frequently sought a boyfriend as someone with whom she could finally talk. In a couple of instances, both parents cooperated in allowing their child to live with another family. Teenagers frequently said, "All my parents do is tell me what is wrong with me and what to do." The pregnancy was a symptom of a lack of intimacy in the family and a self-defeating attempt at a workable solution. Many a teenage girl said with a great deal of relief that since the conception she could talk to her parents (father) for the first time, and that he was not the kind of person she had thought he was—aloof and hostile. The parents, in turn, said that they had not realized that their daughter needed help. She had always seemed so quiet and self-reliant.

### Psychological Problems

There was a great deal of denial of psychological problems. One patient whose mother died from cancer at age 14 wandered around as if she were in a daze for several weeks after she discovered she was pregnant. She repeatedly denied she needed help even though she had no one to whom she could turn and no solution. Her employer finally took it upon himself to help her despite her denial. Thus, the patient often expressed her conflicts in actions, not words. Frequently she did not know the age of her parents, nor any details of their lives, and burst into tears when asked about them.

Older married women who sought abortion had usually experienced an unstable marital relationship for years. Another child in this situa-



tion would be intolerable. There had been very few things that she and her husband had been able to discuss over the years. Sometimes one parent was Catholic and the other Protestant, and one of the areas in which they had been unable to establish rapport was that of contraception. A couple of women were preguant by men other than their husbands. This presented serious problems when it was necessary that the husband sign permission for the abortion.

### Minnesota Multiphasic Personality Inventories:

The data from the MMPI's are shown in Figure 1 as the mean plus or minus one standard deviation. While there is considerable spread on each scale, the mean profile indicates a high degree of psychopathology. With the exception of scale 5 (male-female) and 1 (Hypochondriasis), the mean of every scale is above the 55th percentile. The profile is abnormal in the so-called neurotic area (scale 2 and 3), and in the so-called psychotic area (scales 6, 7, 8, and 9). Social inversion is also abnormal. The mean profile describes a woman who is depressed and hysterical, who acts out her psychological conflicts, who has transient and superficial relationships, and who tends to test the limits of society. In addition, she is somewhat paranoid, anxious, socially inverted, and tends to have some unusual thought patterns similar to patients with schizophrenia.

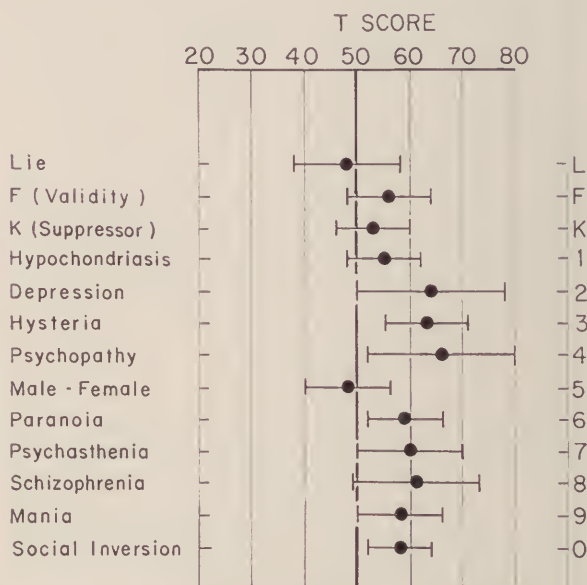
These data are fully consistent with the Clinical Evaluations (*Vide Supra*), and confirm those observations. Since the MMPI tends to underestimate psychopathology, these data indicate a severe degree of psychopathology in these women.

### Discussion

These findings indicate that many of the "accidental" pregnancies are, in fact, not so accidental and, in essence, represent the end result of a complex emotional conflict. They conform to those cases reported by other<sup>1-3</sup> and amplify and extend those findings of Simon, Sentura, and Rothman.<sup>4</sup>

The degree of psychopathology and family pathology herein reported implies that these women almost without exception need some kind of psychiatric help. Yet the bulk of these patients could not afford treatment, nor did they want it. However, when it was explained to them that their pregnancy represented a symptom of the problem they had in relating to men, they usually found this insight most revealing.

Now that women are increasingly being allowed to determine with their physicians the course of events between conception and quickening, it is important that the obstetrician-gynecologist, the general surgeon, the family physician, or any other physician seeing these patients be aware of this psychiatric syndrome.



**Figure 1: Minnesota Multiphasic Personality Inventory Data. N=43; Data are shown as mean  $\pm$ 1 standard deviation.**

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**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

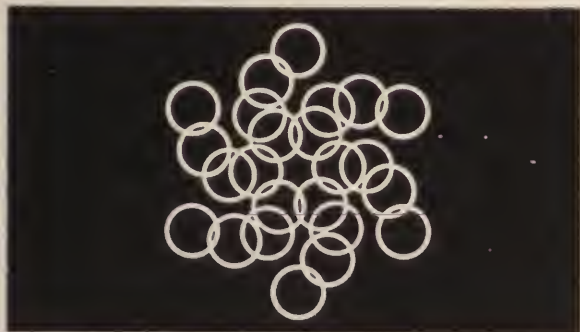
**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## **alcoholism section**

# The Alcoholic Rehabilitation Program in the Prince George's County Division of Parole and Probation

**RICHARD W. ESTERLY**

Parole and Probation Agent  
Prince George's County Division of  
Parole and Probation

Drinking alcoholic beverages may be thought of as a learned response to a situation. This situation may be social pressure, cultural norms, curiosity, or any number of other factors. If the initial drinking of alcoholic beverages (or later drinking, for that matter) leads to the reduction in the strength of a drive (being a state of tension resulting from an unsatisfied need), then the individual will be more likely to repeat that response when confronted with the same or similar situation. To the extent that alcohol reduces tension, worry, and anxiety, it serves as a source of reward to the individual. Although this does not explain the addictive character of alcoholism (assuming that there is one), it does explain how the individual excessively drinks to the point where the pharmacological addiction is established.

Conger (1956)<sup>1</sup> states that the one apparent exception is the man whose drinking is, at least socially, more punishing than rewarding. The man who is alienating his wife, his boss, and his friends hardly seems to be socially rewarded for drinking. However, two factors should be considered here. One is the immediacy of reinforcement. Immediate reinforcements are more effective than delayed ones. This learning principle is called gradient of reinforcement. It may be that, according to this principle, the immediate reduction in anxiety more than compensates for the punitive attitude of the man's wife the next morning. The other factor is the amount of drive and conflict. The personal anxiety-reducing affects of alcohol may, if the anxiety is great enough, constitute greater reinforcement than the competing social punishments.

In addition, if alcohol removes the fear-motivated restraint and conflict situations and permits the satisfaction of the drive whose goal reflexes have been inhibited by conflict, further reinforcement may be provided. These drives may involve orality, aggression, dependency, repressed or suppressed heterosexual or homosexual needs, or exhibition, to name but a few of the needs or drives postulated by various authors as frequent among alcoholic personalities.

Finally, if conflict per se is tension-producing, resolution of the conflict by means of alcohol could itself serve as another source of reinforcement. Based upon this formulation, there are two basic approaches to the modification of the learned drinking behavior. One is to treat the drive and the other is to treat the behavior. Due to the cost, time, and proficiency required to



engage in indepth psychotherapy, many clinics and programs are providing behavior therapy (symptom treatment or action therapy). As in psychotherapy, behavior therapy provides a non-punishing audience in the expectation that repressed responses will return and be dealt with, which will reduce the tension associated with that response.

In 1961, Berger N. Bankston felt the need to provide a treatment process for the alcoholic offenders who were appearing in the court system. He had the insight and compassion to recognize the plight of alcoholics caught in the vicious cycle of alcoholism and the symptomatic nature of their behavior that was bringing them before the court. Armed with this insight and much determination, he approached the court and requested that those offenders appearing in court with an obvious drinking problem be sentenced to probation with mandatory attendance at his newly formed Alcoholic Rehabilitation Unit (ARU).

What started from these meager beginnings with a monthly meeting held in the courthouse, has grown under Mr. Bankston's guidance to a comprehensive program consisting of three weekly meetings situated in space donated by churches in different parts of the county, servicing approximately 220 offenders with varying degrees of alcoholic problems. Four parole and probation agents voluntarily work directly in the program and are assisted by graduates of the program who return voluntarily to give what assistance they can in counseling and bringing speakers from AA. These agents are all sent, by the Department of Parole and Probation, to the Rutgers Summer School of Alcohol Studies and attend many inservice training programs conducted by this department and other agencies in the state. It is worth noting that the health department's alcoholism center and mental health clinic, the Department of Vocational Rehabilitation, Department of Social Services, and Department of Employment Security in the county reciprocally cooperate and exchange in inservice training programs and fulfilling the many needs of the alcoholic. The various universities in the area have also cooperated by including the ARU in their inservice training programs. Doctorate and master degree candidates conduct counseling groups which are very beneficial. The offenders with severe psychological problems are referred to the mental health clinics for more intensive indepth psychotherapy.

In recognition of the complexity of the nature of alcoholism, the ARU is wide in scope and diversity of materials used. The program uses a collection of educational, alcoholism, and mental

health films purchased by donations of the group through the coffee fund. The program also uses AA speakers, role plays, outside professional speakers, and group discussions which are led by successful members of the group. This enhances the cohesiveness of the group and promotes group identification. Due to the devastating effect of alcoholism on the family, the spouses of the alcoholic offender are encouraged to attend and meet in their own group and discuss problems which are common among the families and possible solutions.

### Evaluation

In order to evaluate this program, it is necessary to deal with the problem of selecting a criterion of success. One of the most important criteria, as far as law enforcement agencies are concerned, is whether the person is having significantly fewer criminal arrests. Of course, this is also an important consideration for the offender and the general public. Walter Clark (1966)<sup>2</sup> has pointed out that the problem of defining the alcoholic is done in court and defined operationally as interpersonal problems, instead of excessive drinking, concern about own drinking, or possible addiction and dependence. Of course, the various constellations of indices may be recognized in court or later while under probation or parole supervision. The criterion of number of arrests is also valid, in the sense that if a person is having problems in other areas, then chances are that the person will eventually end up in court.

D. M. Gallant, et al (1968)<sup>3</sup> found that compulsory attendance for parolees at an alcoholism clinic resulted in much better attendance, a better record of employment, a lower recidivism rate, a lower rate of parole violation and a higher rate of abstinence than in a group of voluntary attendance parolees. Margolis, et al (1964),<sup>4</sup> found that people that were required by the court to attend psychotherapy sessions became more involved and derived greater benefit than those who were requested, but not compelled to attend. This writer recently conducted an experiment to evaluate the nine-year-old Alcoholic Rehabilitation Unit within the Department of Parole and Probation. The specific hypotheses which were tested are as follows:

**Hypothesis #1**—Offenders who attended the ARU will have fewer arrests in the time which has elapsed since attending than in a similar time span prior to attending.

**Hypothesis #2**—ARU attenders will have fewer arrests since attending than would a control group of offenders matched in sex, age, and crime, but not attending the ARU.



## Method

The experimental group for this study was the total number of probationers and parolees who graduated from the ARU in 1966, with the exception of 14 who had had their probation revoked, four women, and three who did not attend regularly because of employment or health reasons. These were excluded because it was felt that a truer picture of the worth of the program could be obtained by using only those who attended regularly. The experimental group was required by the court or the parole board to attend the ARU during their period of parole or probation (range of six months to three years—average: 1.08 years). They were required to attend every week of the year except for Christmas and New Year's Day. The control group was selected from the arrest books of Prince George's County and were matched by choosing a person of the same sex and age who committed the same crime on or about the same time as a member of the experimental group. The only difference was that because they were sentenced by a particular judge or in a particular courtroom, or the drinking was not brought out in court, they were given a sentence which did not include attendance at the ARU (eg, fine, suspended sentence, jail, etc).

It should be noted that 18 of the offenders (40%) were under 35 years of age. This may be attributed to the fact that with the knowledge and understanding of alcoholism now available, the problem is being detected at an earlier age. The mean age for the ARU group was 38.7 years and, for the control group, 38.0 years. In each group of 45 offenders, 30 of the group had committed crimes against other persons, five had committed crimes against property and ten had committed crimes against society.

## Results

The results of this experiment do support the stated hypotheses. The following is a breakdown of the hypotheses and the data relevant to each hypothesis:

**Hypothesis #1**—Offenders that attended the ARU will have fewer arrests in the time which has elapsed since attending than in a similar time span prior to attending.

In order to test this hypothesis, the time which has elapsed since first attending the program was computed and then a similar time span prior to attending was computed for each case. This time span ranged from 3½ years to six years. This same process was completed on the control group. It was found that a much larger proportion of the control group (66%) than the ARU

group (37%) had not been arrested in the prior time span. This is not surprising since people who drink excessively generally do have more problems with the law. In the ARU group, the average number of arrests prior to attending the ARU was 1.69 a person and the average since attending the program was 0.58.

Using a test for significant differences between two independent samples showed that the difference was statistically significant. Unfortunately, this cannot be interpreted to mean that the offenders' lives have been radically changed, but it is significant to the individual and society that the person was not being involved in the law enforcement process to the extent that he was previously. It should be noted that the means for the control group in the before and after comparison were 1.18 and 1.42 respectively, which shows a definite increase (but no significant differences). Further evidence for the effect of the program was obtained when a test revealed no significant differences between the means of the two groups in the prior condition.

**Hypothesis #2**—ARU attenders will have fewer arrests since attending than would a control group of offenders matched in sex, age, and crime, but not attending the ARU.

In order for this evaluation to be of any consequence, it was necessary for the control group to be included. There are many factors which cannot be controlled by the experiment. For example, on July 1, 1968, Senate Bill 389 was passed in Maryland which no longer made public drunkenness a crime. Therefore, it would be difficult to interpret the results without a control group. Also, there is a margin of error in the arrest records of both groups. It is expected that the error is not greater in one group than in the other. Also, there is the factor of police policy, which is subject to change. The average number of arrests since attending the program for the ARU group is 0.58 and for the control group not attending the program 1.42. Using a T-test for significance between independent samples showed that the differences were statistically significant, with or without extreme cases.

When working with alcoholism, it is necessary to measure success in degrees. No supervising agent even dreams of his clients never getting into trouble again. Because of this, it is worth noting also that the members of the ARU group who were charged after their baseline arrest went 29 months on the average before being charged again. Members of the control group went only 16 months on the average before being arrested again.



## Discussion

Using the number of arrests as the sole criterion of success has many limitations. For example, this writer has not even mentioned the amount and frequency of drinking, troubles with employment, family or friends, personality disorders, or a new maturity in coping with tension, but the criterion of number of arrests does rate as Clark's (1966) No. 1 Index of Problem Areas. In addition, if the alcoholic continues drinking, he will usually end up in court. In order to consider these other criteria for success, a follow-up schedule should include an interview and value and attitude scale prior to attending the ARU, an interview and value and attitude scale after completion of the program, and a third interview and value and attitude scale from three to six months later. This type of follow-up would give an account of objective value and attitude change and a subjective evaluation of his interpersonal relationships, his employment record, and his drinking behavior. This type of longitudinal study would be retrospective-prospective and could avoid the pitfalls of selective recall and reconstruction. An obvious fault of this study is the effect of being under supervision, per se, and not attending the ARU. It may be that the interpersonal relationship between probationer and agent is the factor most influential in rehabilitating the alcoholic. Because of this factor, any further follow-up should include a control group consisting of men that are on probation but not attending the ARU and a control group such as the one used in this study.

In conclusion, this study does seem to support the proponents of the ARU. The program has affected the men in the ARU group to the extent that they have been arrested fewer times since attending. It is hoped that through the educational and other techniques used, the offenders have learned new alternatives to alcohol ingestion that are less harmful to them.

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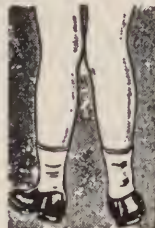
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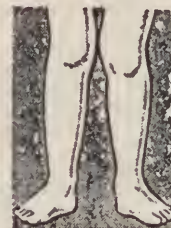
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3, 4, 5 May 1972  
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Ample space is available; however, it is suggested that applications be submitted as soon as possible.

### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO

NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

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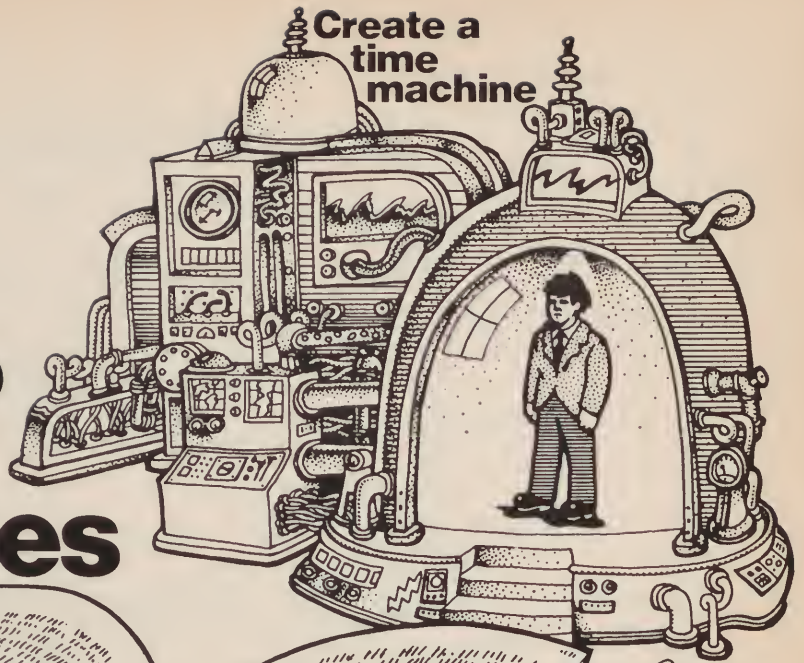
Fill in and mail to: Chairman, Exhibit Subcommittee  
Medical and Chirurgical Faculty  
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: \_\_\_\_\_
2. Please attach a 50-100 word description of the exhibit: \_\_\_\_\_
3. Give amount of space required, depth, width, and height: \_\_\_\_\_  
If exhibit has side panels, are depth and width included above? \_\_\_\_\_  
If not, what additional space is required? \_\_\_\_\_
4. Electrical or other requirements: \_\_\_\_\_
5. Has exhibit been shown at other medical meetings? \_\_\_\_\_
6. Name and title of exhibitor: \_\_\_\_\_
7. Name of institution cooperating in the exhibit: \_\_\_\_\_
8. Address of exhibitor: \_\_\_\_\_

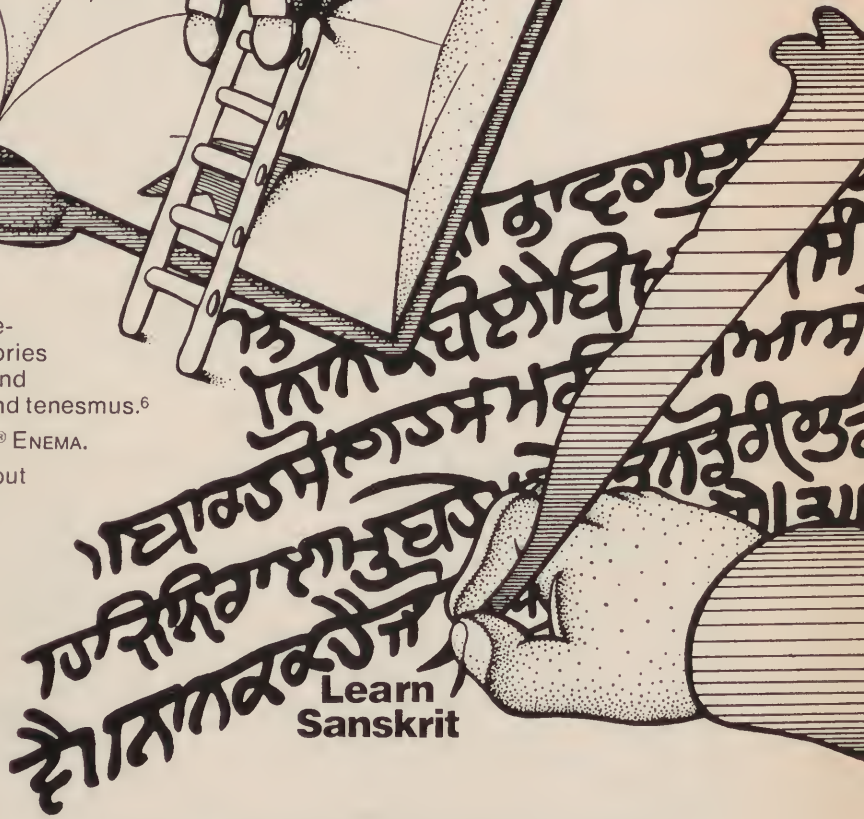
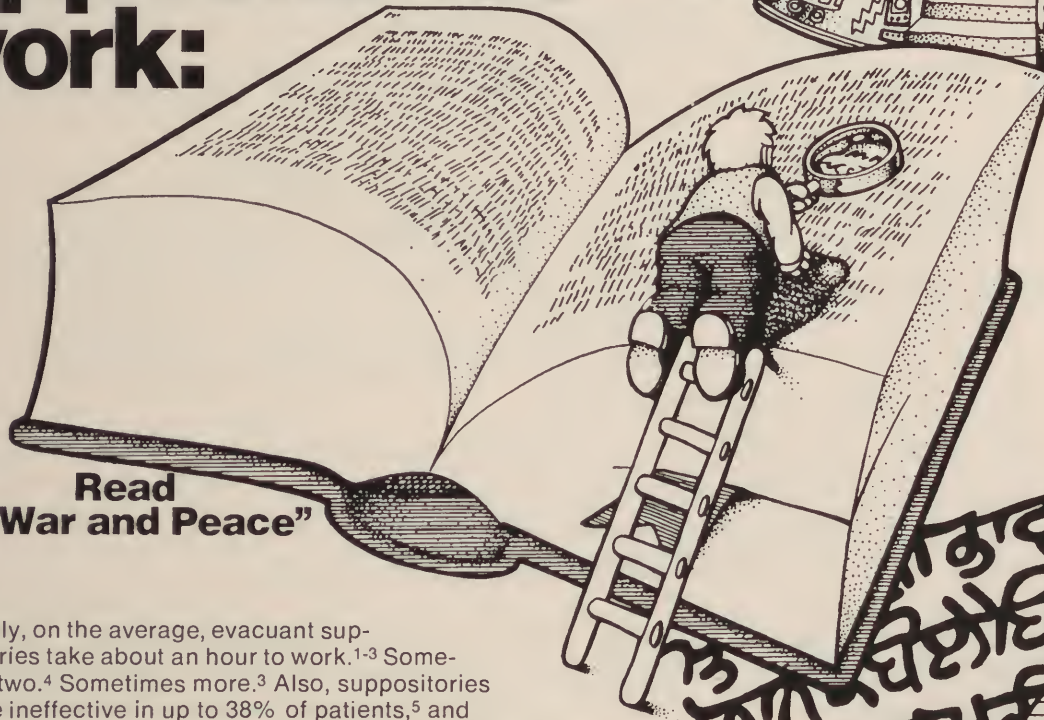
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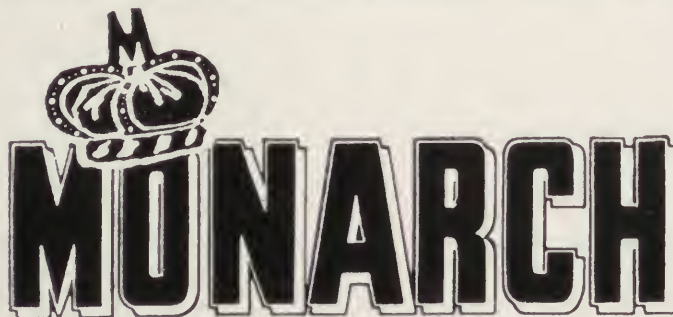


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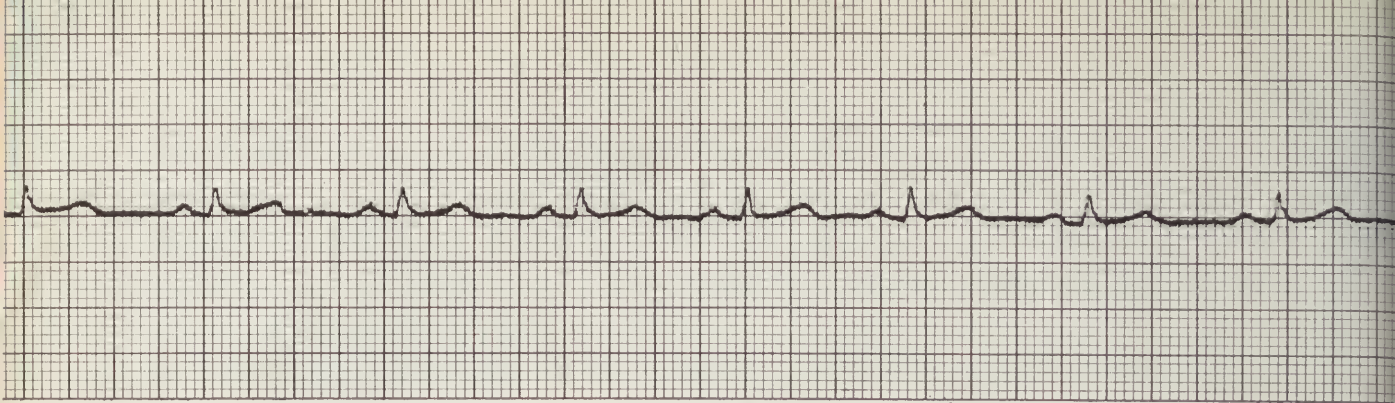
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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other

antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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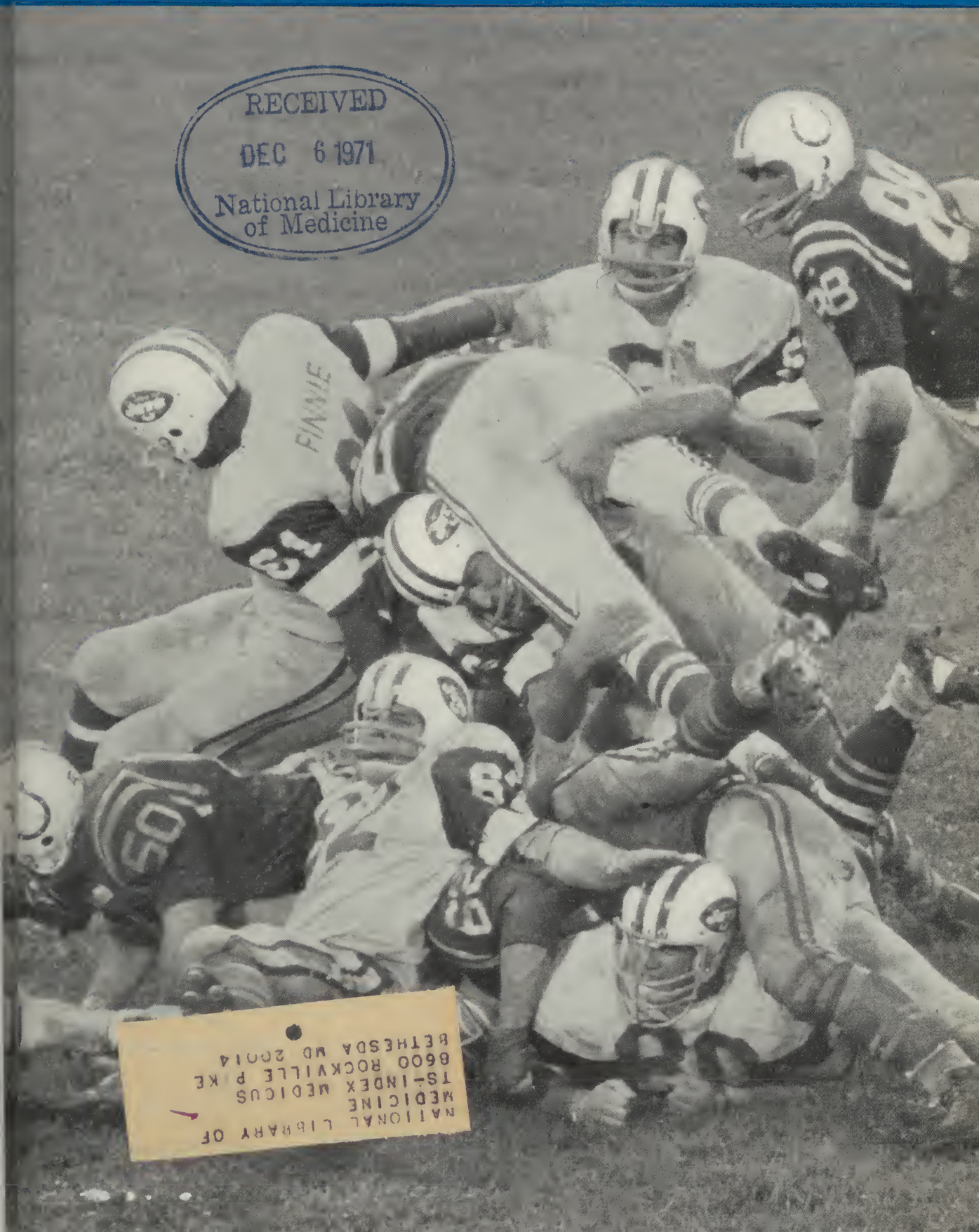
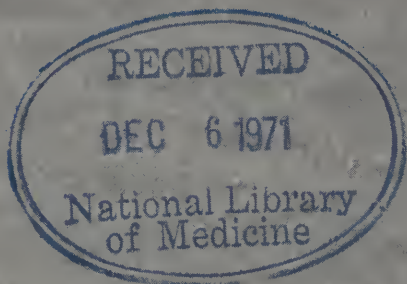


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## STATE MEDICAL JOURNAL

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NOVEMBER 1971



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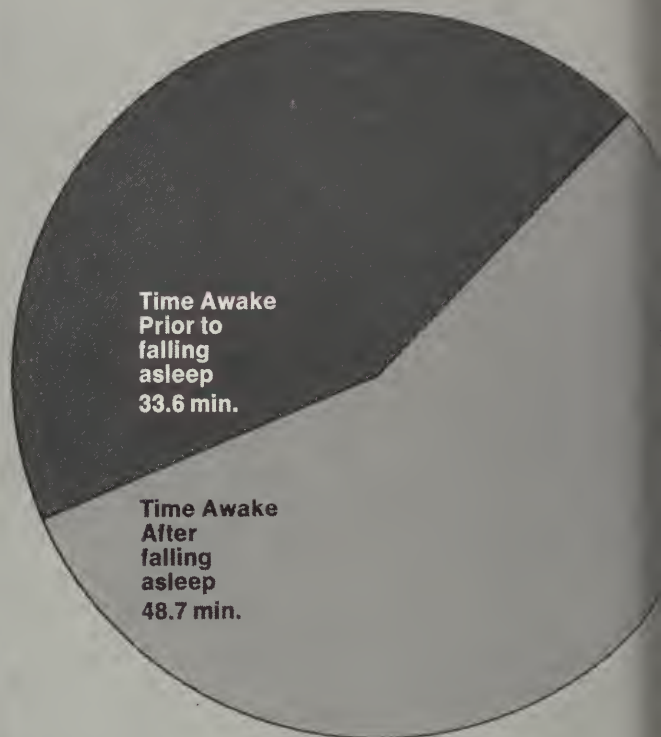
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

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**References:** 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

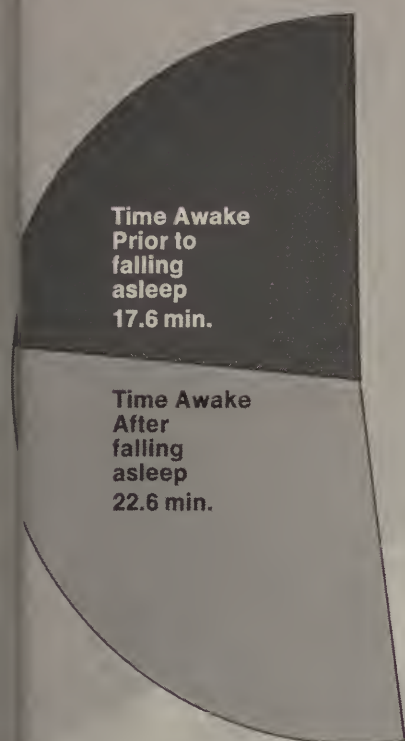
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# and slept through the night

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ag sleep laboratory measurements in cited studies

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Time required to fall asleep	33.6 min.	17.6 min.
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**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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# Maryland State MEDICAL JOURNAL

VOLUME 20 NOVEMBER 1971 NUMBER 11

## ARTICLES:

### Stress Limits in the Young Athlete, Ellsworth R. Buskirk, PhD .... 35

"If interactions of the body with various environmental factors are considered, it is apparent that we live in a complex world. Nutritional, parental, peer, and environmental influences have an important impact on the growing and developing child."

### Sports and Physical Fitness Programs for Girls of Western Europe Compared With Those in Maryland

Mrs. Randall C. Coleman ..... 38

"While so much emphasis in physical education is on the training of male athletes to represent their schools in competitive sports, let us spend some time here thinking about the female half of the school community—the girls who are preparing in high school for their future lives."

### Field Diagnosis of Athletic Injuries, Stanford A. Lavine, MD. .... 45

"Diagnosis is derived from the Greek word 'gigroskein' meaning to know. It is defined as the process of determining by examination the nature and circumstances of a condition and the decision reached from such an examination."

### Use and Misuse of Physical Therapy Modalities in the Treatment of Athletic Injuries, B. Stanley Cohen, MD ..... 48

"In approaching the treatment of athletic injury, many questions need to be considered. Primary, of course, is the nature of the injury, its location and extent, and whether it is acute or at a later or chronic stage. Next, one must consider the desired effects of the therapy and the available modalities to achieve these effects. This decision includes the physical principles involved, the physiological effects, and the potential dangers. Finally, the selection of the modality and the methods of application must be considered."

### Preservation of Sight in Sports, Joseph W. Berkow, MD ..... 57

"With the exception of boxing, most sports injuries to the eye are accidental. In most sports, ocular damage is usually due to contusion injury to the eye. This may be from the blunt force of a ball or other piece of equipment, or from forceful contact with the body of a team mate or opponent. Therefore, the chief goal in the preservation of sight in sports is the protection of the eye from accidental trauma."

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## EDITORIAL AND BUSINESS OFFICE:

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ON THE COVER: This Sportsmedicine cover by Baltimore Colts' photographer Chuck Hickey pictures a pileup of the World's Champion Baltimore Colts and the New York Jets. It would appear that medical assistance is in order for these sportsmen!



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# Doctors in the News

Anselmo M. Alliegro, MD, Baltimore, has been elected and named a Fellow of the Royal Society of Health in London. Congratulations!

\* \* \*

Six Maryland doctors have been granted Fellowships in the American College of Cardiology, the national medical society for specialists in cardiovascular diseases.

Leonard Scherlis, MD, Baltimore, the ACC Governor for Maryland, listed the new MD Fellows as William P. Baker, Bethesda; Albert M. Antlitz, C. Richard Conti II, Chris Papadopoulos, and Robert T. Singleton — all from Baltimore; and Peter B. Halmos, Cumberland. These six doctors have fulfilled stringent membership requirements based on several years of practice and specialty certification.

\* \* \*

Joseph V. Osterman, MD, assistant professor of microbiology at the School of Medicine, University of Maryland at Baltimore, has received a grant of \$6,250 from Research Corporation of New York City to study the replication of mosquito-borne viruses and to develop techniques for identifying and classifying new viruses.

\* \* \*

Doctors Finney, Trimble, Wilgis, and Stonesifer are pleased to announce the association of John N. Classen, MD, and Albert C. W. Montague, MD, in the practice of general, thoracic, and vascular surgery at 5820 York Road in Baltimore.

\* \* \*

A Baltimore surgeon, George G. Finney, Sr., MD,

son of the first president of the American College of Surgeons, has received the 1971 Distinguished Service Award of the American College of Surgeons. Dr. Finney graduated from Princeton in 1921 and received his MD degree from The Johns Hopkins University School of Medicine in 1925.

In presenting the award, the ACS president, Howard Mahorner, MD, paid high tribute to Dr. Finney for his long and dedicated service in surgery as well as his service in civic affairs.

"It is the fortunate lot of certain men to have inculcated from birth a tradition of public service," he said, adding: "Steeped in such a tradition, and dedicated to extending it over a medical career verging on half a century, George G. Finney has exemplified for thousands of his patients, colleagues, and friends the highest ideals of selfless devotion to the well-being of his fellow man.

"A leader in civic and community affairs, he was similarly valiant and meritorious in his service as chief surgeon of a general hospital during the war in the South Pacific, receiving the Bronze Star Medal and the Legion of Merit for his extraordinary conduct.

"His long and devoted service to the American College of Surgeons was crowned by his chairmanship of the Board of Governors."

The award was last made in 1969.

\* \* \*

According to a recent story in the *Hagerstown Herald*,

Washington County has gained a new family doctor, bringing to 25 the number of general practitioners serving its 103,000 residents. He is Hugh Frazer, MD, a former medical missionary to The Congo, who has opened offices in the Medical and Professional Center at 580 Northern Avenue.

But the county still needs three or four more family doctors to adequately serve its population, according to Howard N. Weeks, MD, chairman of the physicians' procurement committee of the Washington County Medical Society.

A graduate of the Ohio State University Medical School, Dr. Frazer interned and took resident training at Miami Valley Hospital in Dayton before going overseas as a missionary with the United Methodist Board of Missions.

\* \* \*

Another MD in the news is Marvin A. Leder who has been appointed director of medical education and ambulatory services for the North Charles General Hospital in Baltimore. He will be directly responsible for establishing a coordinated, continuing teaching program for both the house and attending staff.

A graduate of the State University of New York College of Medicine at Syracuse, Dr. Leder established private practice in Flushing, N.Y., in 1965 limited to internal medicine. When Dr. Leder established private practice in Baltimore last year, he was an assistant attending physician at Sinai Hospital until his ap-



pointment at North Charles in September.

\* \* \*

A former Baltimorean, **Susan C. Dees, MD, FAAP**, professor of pediatrics, Duke University School of Medicine, has been named by the American Academy of Pediatrics to receive the 1971 Bret Ratner Award for outstanding contributions in the field of pediatric allergy.

Dr. Dees received her MD degree from Johns Hopkins in 1934. She served as medical service house officer at Johns Hopkins Hospital during 1934 and 1935 and as an intern in pathology at Baltimore City Hospitals in 1936 and 1937. In 1938, she returned to Johns Hopkins as assistant dispensary physician. She departed Baltimore in 1939 to join the Duke University School of Medicine.

\* \* \*

Word comes from the Baltimore City Medical Society that three of their group have recently passed their Boards. **John B. De Hoff, MD**, and **Edyth H. Schoenrich, MD**, have met the requirements of the Board of Preventive Medicine and Public Health. **Masoud Azadi, MD**, has passed his Internal Medicine Board.

## Did You Know?

- About 2 out of every 5 Americans own some form of health insurance to help pay the costs of out-of-hospital prescribed drugs.

- Of those covered, 4 out of every 5 are protected by insurance company major medical expense plans.

- This insurance normally requires only that the drugs be prescribed by the attending physician and that their costs be both customary and reasonable.

# Medical News Briefs

The American Board of Family Practice announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two-day period on April 29-30, 1972. Information regarding the exam can be obtained by writing:

Nicholas J. Pisacano, MD,  
Secretary  
American Board of Family Practice, Inc.  
University of Kentucky  
Medical Center  
Annex #2, Room 229  
Lexington, Kentucky 40506.

## BLOOD DONOR TESTS REQUIRED

The American Association of Blood Banks (AABB) has amended its standards to require testing of all donor blood and blood components for the hepatitis-associated antigen. Since October 1, blood banks must fulfill this requirement for accreditation by the Association.

"These new tests will increase the cost of blood processing in the United States by perhaps five million dollars, but will enhance greatly the quality of transfusion service," said Dr. John Bernard Henry, President of the Association.

The changes in the Association's standards require rejection of a donor "if his blood has ever been known to contain hepatitis-associated antigen" and say:

"All donor blood shall be tested for hepatitis-associated antigen using reagents and technics specified by the Division of Biologics Standards, or proven to have equivalent sensitivity and specificity. The blood shall not be used for

transfusion unless the test is non-reactive. In an emergency, blood may be transfused before completion of the test for hepatitis-associated antigen. If the test is subsequently positive, the recipient's physician should be notified."

This requirement, the Association said, is to include any blood component collected by plasmapheresis on each occasion whether the component is to be transfused as a single donor unit or is to be pooled for fractionation.

Among the recommendations of the Ad Hoc Committee was that the AABB in cooperation with other appropriate agencies establish a national program to develop a hepatitis registry of HAA positive donors, recipients, and laboratory personnel for purposes of epidemiologic study; provide a proficiency testing service and appropriate controls and reference standards; provide confirmation of HAA positive blood samples for other hospitals; and investigate the subspecificities of HAA.

HAA positive donors must be so notified and warned against future donations, said the Committee. This information should be considered as privileged. Although the HAA carrier state is not now a reportable condition, hepatitis is a reportable disease. Notification of the local Department of Public Health may be advisable.

"It must also be recognized that in its present stage of development," said the Committee, "routine HAA testing of blood is only an adjunct to other methods of proper donor screening and selection."



# **your medical faculty at work**

**by John Sargeant  
Executive Director**

The Executive Committee met on October 14, 1971, and took the following actions:

1. Adopted the House of Delegates minutes for the September 11, 1971, session.
2. Agreed, in the future, to tape the House of Delegates sessions, rather than having a stenotypist present. The verbatim record will be transcribed only if necessary for clarification or other purposes. This will effect a substantial cost saving.
3. Agreed to cooperate in a professional liability survey of the membership with the CNA Insurance Company by providing addressed envelopes and a covering letter.
4. Approved the expenditure of up to \$500 for the second Annual Emergency Medical Services Symposium scheduled for 1972, such money to come from the Educational Fund.
5. Declined to provide financial assistance to the ophthalmology group to assist in legislative activities involving eye care, and reaffirmed its desire to continue providing staff assistance and other services as it has in the past.
6. Established Executive Committee meeting dates for 1972.
7. Approved the recommendation of Leeds E. Katzen, MD, Ophthalmologist of Baltimore, for appointment to the Medical Advisory Board of the Department of Motor Vehicles.
8. Designated the Executive Director to serve as Faculty representative on the Advisory Council to the Regional Medical Program to replace Paul F. Guerin, MD, who has resigned because of the press of other activity.
9. Referred a request from the Baltimore City Medical Society to the Professional Medical Services Committee for study and recommendation. The request was that the Faculty, when dealing with physicians' income, also consider salaries offered to physicians who work on a full time basis.
10. Discussed with representatives of the United States Public Health Service, the Lipid Evaluation Study taking place at the Social Security Administration and the letter used in contacting physicians who have patients participating in the study.
11. Declined to endorse a proposal of the Maryland Public Health Association that would have banned health columns in newspapers because it was felt they performed a useful purpose and that no specific instances of misdiagnosis had been presented, although alleged in the statement of that Association.
12. Approved a recommendation of the Subcommittee on Alcoholism that the Faculty make known to Component Societies that assistance is available through members of that Subcommittee for physicians who have an alcoholism problem.
13. Agreed to explore the possibility of a joint annual session with the Maryland State Dental Association.
14. Agreed to a joint meeting of Executive Committees of the Faculty and the Maryland Hospital Association.



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# executive director's newsletter

November 1971

## DRUG ABUSE EMERGENCY MANUAL

A new treatment manual for Drug Abuse Emergencies is now available from the Faculty office. Published as a joint endeavor of the Faculty and the State Drug Abuse Administration, copies have been sent to all hospital emergency rooms as well as other interested individuals.

## SMALLPOX VACCINATIONS

Physicians are reminded that, contrary to public belief, it is quite easy to send vaccination certificates for smallpox and cholera to local or State Health Departments for validation. This can be done by mail.

## RETURNING VETS

Medically-trained veterans are returning from military service and are seeking work with physicians, some in a specialty, some in general practice. For more information, contact Tom Moses, MEDIHC (Military Experience Directed Into Health Careers) at 1301 York Road, Lutherville, Md. 21093.

## ORCHESTRAL ALLIANCE

An appeal is being made to physicians, wives, and allied professional personnel who are interested in forming an orchestra - strictly for pleasure. If sufficient interest exists, an organizational meeting will be called to discuss it further. Please let us have name and address, in writing, if you are interested.

## BNDD NUMBERS

As of October 1, 1971, physicians should indicate on all prescriptions the new BNDD number assigned by the Department of Justice. When the original application was sent to physicians in April, a copy of the completed form was to have been retained by the physician. The number on this form will be the physician's permanent number and will remain his until it is cancelled.

## PHYSICIAN PRESCRIPTION BLANKS

It is illegal for a physician to use prescription blanks containing the name of a pharmacy or pharmacist. It is also unethical for an ophthalmologist to use a prescription blank containing the name of an optician.

## BLUE SHIELD SURVEY RESPONSES

The results of the recent survey concerning attitudes of physicians to Blue Shield are as follows:

1,285 physicians replied to the survey, with 1,135 indicating they were participating physicians and 136 stating they were not; 14 did not answer this question.



BLUE SHIELD  
SURVEY  
RESPONSES  
(cont'd)

Of the 1,135 who were participating, 969 stated they planned to continue as participants.

Approving the concept of paid-up full benefits for low income subscribers, were 685, or 60%, of the participating physicians; and 58 of the non-participating physicians.

In reply to the question as to satisfaction with the present policies of Plans A, B, and C, the following was revealed:

Plan A: Yes, 525 or 46% - No, 543 or 48%

Plan B: Yes, 497 or 44% - No, 558 or 49%

Plan C: Yes, 754 or 66% - No, 278 or 24%

In other responses, it was learned that only 330 physicians indicated they had any complaints with respect to Blue Shield, or 29%; while 707, or 62%, said they had none.

The survey also revealed that 936, or 83%, feel Blue Shield services are of benefit to them; 862, or 76%, feel that the individual participating physician contract should be continued.

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When one physician telephones another, it is proper for the secretary or nurse to have the physician calling ready to speak when the physician who has been called answers.

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# Doctors take note...

## Miscellaneous Meetings

- January 3-7 Workshops in the Physiology, Diagnosis, and Treatment of Electrolyte and Acid-Base Disorders. University of Pennsylvania School of Medicine, Philadelphia. Purpose: Provide "in depth" discussion of physiological and bio-chemical bases of clinical fluid, electrolyte, and acid-base problems to provide rationale for modern approach to diagnosis and therapy. Contact: Registrar, Post-graduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.
- November 28 13th National Conference on Medical Aspects of Sports, New Orleans. Meets in conjunction with Annual AMA Clinical Convention. Contact: Committee on Medical Aspects of Sports, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.
- December 1
- December 9-10 Pediatric Pulmonary Function and Disease. Louisiana State University School of Medicine, New Orleans. Sponsors: American Thoracic Society and others. Contact: Course Registrar, Louisiana Thoracic Society, 333 St. Charles St., New Orleans, La. 70130.

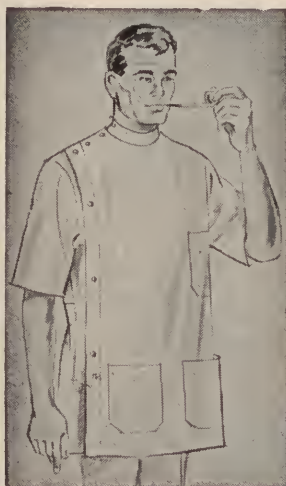
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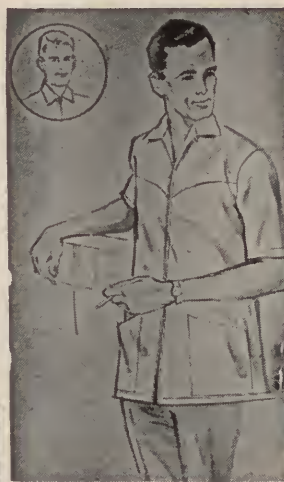
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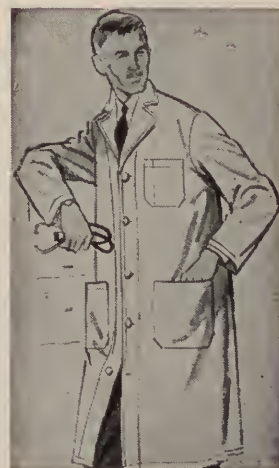
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# American Association of Medical Assistants

## Baltimore Chapter

The September meeting was held at Med-Chi with Alfred Cole, MD, as the guest speaker. Dr. Cole gave an enlightening talk on depression, its manifestations and treatment. He reviewed case histories of various types of depression and anxiety encountered in his 25 years of practicing family medicine and obstetrics.

Antidepressant drugs, stimulants, and tranquilizers were fully discussed and advantages and possible hazards were cited.

Dr. Cole presented two films. The first, "Diagnosis of the Depressed Patient," reviewed physical, emotional, and psychic symptoms. The second showed Mrs. Dorothy Hartel receiving the "BAMA Medical Assistant of the Year" award. It was presented by Newland Day, MD, advisor to the Baltimore Chapter.

A fund raising project, held at the Garland Dinner Theatre in September, proved to be both profitable and enjoyable. The purpose of this yearly event is to subsidize Baltimore delegates to the national convention. Mrs. Valerie Hachtel is committee chairman.

## Maryland Meeting

The 11th semiannual meeting was held in Ocean City, Maryland on September 11. Following registration, a business meeting was conducted by the president, Mrs. Jean Subock.

The annual auction, with Rita Cobry serving as auctioneer and Dorothy Hartel as cashier, proved to be very profitable.

Henry L. Wollenweber, MD, advisor, in his welcoming address, stressed the need for education. He also gave information needed to attain further knowledge in the paramedical field. It was his view that colleges will offer courses in any desired subject if there is sufficient demand.

Francis Trimble, MD, Medical Director, Planned Parenthood Association of Maryland, had as his topic, "Population Problems and Family Planning."

His statistics showed that the population of the United States, many foreign countries, and the entire world was at an all-time high. This increase has brought accompanying complex emotional, sociological, and economic problems. Voluntary management of population control is the aim of Planned Parenthood. They offer counseling on the great variety of control methods.

Margaret Paxson, MD, clinician for the Planned Parenthood Association of Maryland,



Cole

Wollenweber

Leiby

followed with a talk on, "Why There Should be Sex Education in the Schools." Dr. Paxson travels throughout the state lecturing on the need of sex education in schools. It is her view that the initial education should start with parents, physicians, and teachers. It is especially important that teachers be properly trained before submitting a program to the students, she stressed. She concluded by stating that the unknown and uncertainties cause far more problems than correct information.

The president of the Baltimore Chapter, Mr. William Leiby, served as master of ceremonies at the banquet. The invocation was given by the Reverend Thomas Subock, husband of the president, Mrs. Jean Subock.

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## woman's auxiliary

# Southern Medical Association Ties

The Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland serves as an auxiliary to the state medical society and as a component of the Woman's Auxiliary to the AMA. It also maintains a very close liaison with the Woman's Auxiliary to the Southern Medical Association.

The 65th Annual Meeting of the Southern Medical Association took place November 1-4 in Miami Beach, Florida. "Southern" is therefore very much in the minds of many Maryland physicians and their wives at this time.

Mrs. David S. Clayman of College Estates has just finished her term of office as the Councilor to the Woman's Auxiliary to the Southern Medical Association from the Maryland medical auxiliary. Appointed by the president of the Med-Chi auxiliary to succeed Mrs. Clayman is Mrs. Archie R. Cohen of Clear Spring. Mrs. Raymond M. Yow of Salisbury has been appointed Vice-Councilor. These ladies are very enthusiastic members of Southern's auxiliary and do a fine job of selling memberships in the Southern Medical Association.

The Southern Medical Association was founded in 1906. On November 25, 1924, the Woman's Auxiliary was organized in New Orleans by Mrs. Seale Harris of Birmingham, Alabama. Approximately 20,000 members from Alabama, Arkansas, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia comprise the Southern Medical Association. Since membership of a physician automatically makes his wife a member of the Woman's Auxiliary (without payment of dues), there is an almost equal number of women in its auxiliary.

The Woman's Auxiliary to the Southern Medical Association promotes friendliness and good fellowship among physicians and their families. The auxiliary began the celebration of Doctor's Day to memorialize physicians, both living and dead, through a variety of observances on March 30, using the red carnation as the official symbol. Every component of the Med-Chi auxiliary has cooperated in this project. The governor of Maryland issued a proclamation praising Maryland doctors for their outstanding work and their skills in both preventing and curing ills as well as for developing and disseminating advanced knowledge in medicine and surgery. Throughout Maryland each year, red carnations are presented to doctors and placed in hospital lobbies. Posters are displayed to explain Doctor's Day, medical books are presented to hospital libraries and nursing schools, contributions are made to AMA-ERF, and auxiliaries plan celebrations throughout the state to add fun and camaraderie. Auxiliary publicity chairmen see to it that the media give Doctor's Day as many problems as correct information.

The Woman's Auxiliary to the Southern Medical Association has begun a continuing project of preserving the history and romance of medicine. The Maryland medical auxiliary has made available the history of medicine in Maryland. Books and pictures have been loaned to the Southern auxiliary to further document stories of Maryland's men and women in medicine.

The annual meeting of the Southern Medical Association is traditionally held in November each year in one of the cities within the association's territory. Generally, the format of an annual meeting consists of two parts: scientific



program and exhibits. The scientific work of the Southern Medical Association is divided into 21 sections, running the gamut from allergy to urology.

The annual meeting, while geared primarily to education, also has its moments of relaxation. Thriving on an informal atmosphere — where physicians from every type of practice can meet to exchange ideas — SMA has a widely-known reputation for its "Southern Hospitality." For many years, the SMA meeting has been a wife's choice of a meeting to attend with her husband. Social highlights of the annual meeting include activities planned by the Woman's Auxiliary.

Following the annual meeting, this combination of "fun while you learn" is continued with an association-sponsored post-convention meeting. Low-cost trips, yet deluxe in every way, are available for members, their families, and guests.

It is no wonder that in her annual report to the Med-Chi Auxiliary Mrs. Clayman said: "Come on, you Marylanders. If you are not a member of Southern's Auxiliary, get on the bandwagon now. Get your husbands to join Southern and you will automatically become a member."

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

## **Baltimore City health department**

# Health Corporations: A New Approach For Health Manpower, Cooperation and Care

The following is a short description of the four new nonprofit health corporations established to meet the changing pattern of health manpower and medical care needs of Baltimore City and nearby areas. Developed and brought into being by dedicated representatives of the health, lay, and medical communities, the new corporations represent an evolutionary trend in Baltimore which may ultimately provide medical services, both preventive and curative, to all residents in a satisfactory, effective and efficient manner and at minimal cost to the public and to government.

**Maryland Consortium for the Health Sciences, Inc.** This is the first of the new health corporations. The Maryland Consortium for the Health Sciences was incorporated November 5, 1970 for the development of a coordinated system of health manpower development in schools ranging from the ninth grade through master's programs. The Consortium includes incorporators as representatives from the Baltimore City Medical Society, Baltimore City Health Department, Coppin State College, Bon Secours Hospital, Baltimore City Department of Education (Dunbar High School), Sinai Hospital, Maryland State Department of Mental Hygiene, Provident Hospital, Community College of Baltimore, and Morgan State College.

The Consortium has received a \$135,000 grant from OEO through the National Urban Coalition to develop a coordinated system of nursing education from high school to college involving Dunbar High School, Community College of

Baltimore, and Coppin State College. An additional sum of \$79,000 has been received from the Maryland Drug Abuse Administration to develop drug abuse curricula for the education of professionals in all fields with an interest in drug abuse. Coppin State College will implement this program with Monroe Lerner, MD, Professor of Behavioral Sciences of The Johns Hopkins School of Hygiene and Public Health, as the project director.

**First Maryland Health Care Corporation, Inc.** This corporation was established March 1, 1971 to provide for the development of a Community Health Network in west and northwest Baltimore. An OEO grant of \$98,800 will be applied to this health care delivery project in the area bounded by Washington Boulevard on the south, radially to Jones Falls on the north, corresponding roughly to the City Health Department's Druid Health District. The Corporation is believed to be the first in the United States patterned after the American Hospital Association's AMERIPLAN proposal for health care corporations and will involve the coordination and utilization of hospitals, group practices, private physicians, the City Health Department, and the Baltimore City Medical Society. Incorporators include representatives from the following agencies: Baltimore City Medical Society, Baltimore City Health Department, Sinai Hospital, Bon Secours Hospital, Provident Hospital, Lutheran Hospital, Garwyn Medical Group, Northwest Baltimore Corporation, and the Maryland Consortium for the Health Sciences.



**Maryland Health Maintenance Committee, Inc.** Incorporated early in 1971, this agency has been the recipient of a \$250,000 grant from the Health Services and Mental Health Administration (HSMHA) of the U.S. Department of Health, Education, and Welfare to plan for the development of prepaid group practice units in a system for Metropolitan Baltimore. The organization now comprises 65 members representing a broad spectrum of community groups including insurance groups, unions, hospitals, medical and other professional associations, consumer groups, neighborhood representatives, and the state and local health departments. The Commissioner of Health of Baltimore City is serving as Chairman of the Membership Committee and assisted with arrangements for funding the early work of this group.

**North Central Baltimore Health Corporation, Inc.** Incorporated early in the year, this agency is designated to bring health care providers and community groups in the north central "corridor" of the city together for a united effort in health care delivery. Although its selected ser-

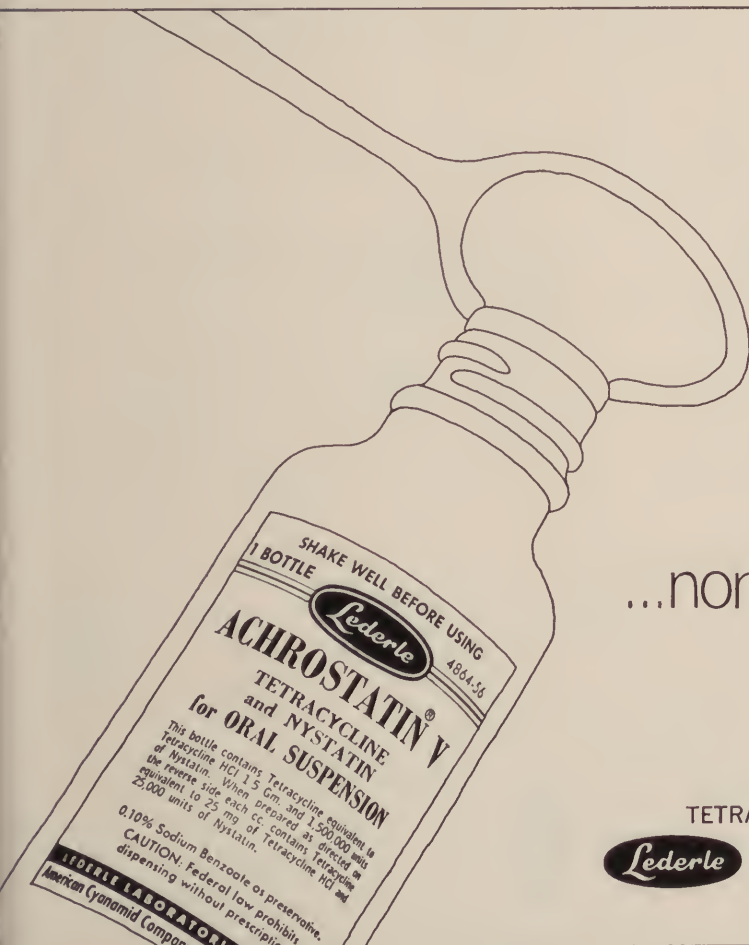
vice area extends to the northern city boundary, the major emphasis is on the Model Urban Neighborhood Demonstration (MUND) project area north of North Avenue, the Remington-Hampden-Woodberry areas, and the Homestead-Montebello neighborhoods. Planning funds in the amount of \$37,000 have been received from HEW through Comprehensive Health Section 314 (e) of the Public Health Service Partnership for Health Act of 1966 as amended.

Participating groups include Coldstream Park Improvement Association, Greater Homewood Community Corporation, Homestead-Montebello Churches, MUND, North Charles General Hospital, Good Samaritan Hospital, Montebello State Hospital, Union Memorial Hospital, the U. S. Public Health Service Hospital, and the Northeast Baltimore Corporation.

John B. De Hoff, MD, Deputy Commissioner of Health, was instrumental in establishing the Maryland Consortium for the Health Sciences and the First Maryland Health Care Corporation and serves as Chairman of the Board of both these agencies.

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# Book Reviews

**GENERAL OPHTHALMOLOGY** by Daniel Vaughan, MD; Taylor Asbury, MD; and Robert Cook, MD. Lange Medical Publications, Los Altos, Calif., 1971.

This soft-cover book is a revision of a publication that first appeared in 1958. It is a concise, up-to-date review of this specialty useful to medical students, residents, and all physicians. It also serves as a useful reference guide to the management of the more common ocular disorders seen in daily practice.

It is interesting to note that this is one of several publications produced in a soft-cover, providing savings over the standard form of hard-cover texts published by most medical publishing houses.

**REVIEW OF PHYSIOLOGICAL CHEMISTRY**, Harold A. Harper, PhD; Lange Medical Publications, Los Altos, California, 1971.

This marks the 13th edition of this book, indicating it has well served its function to provide a more concise source of information than standard textbooks. This is ideal for those readers who want an introduction to the subject or who may desire a review, as is required in preparation for examinations of state and specialty boards.

In soft-cover edition, it has slightly fewer pages than previous editions, because of a change in its format and type face.



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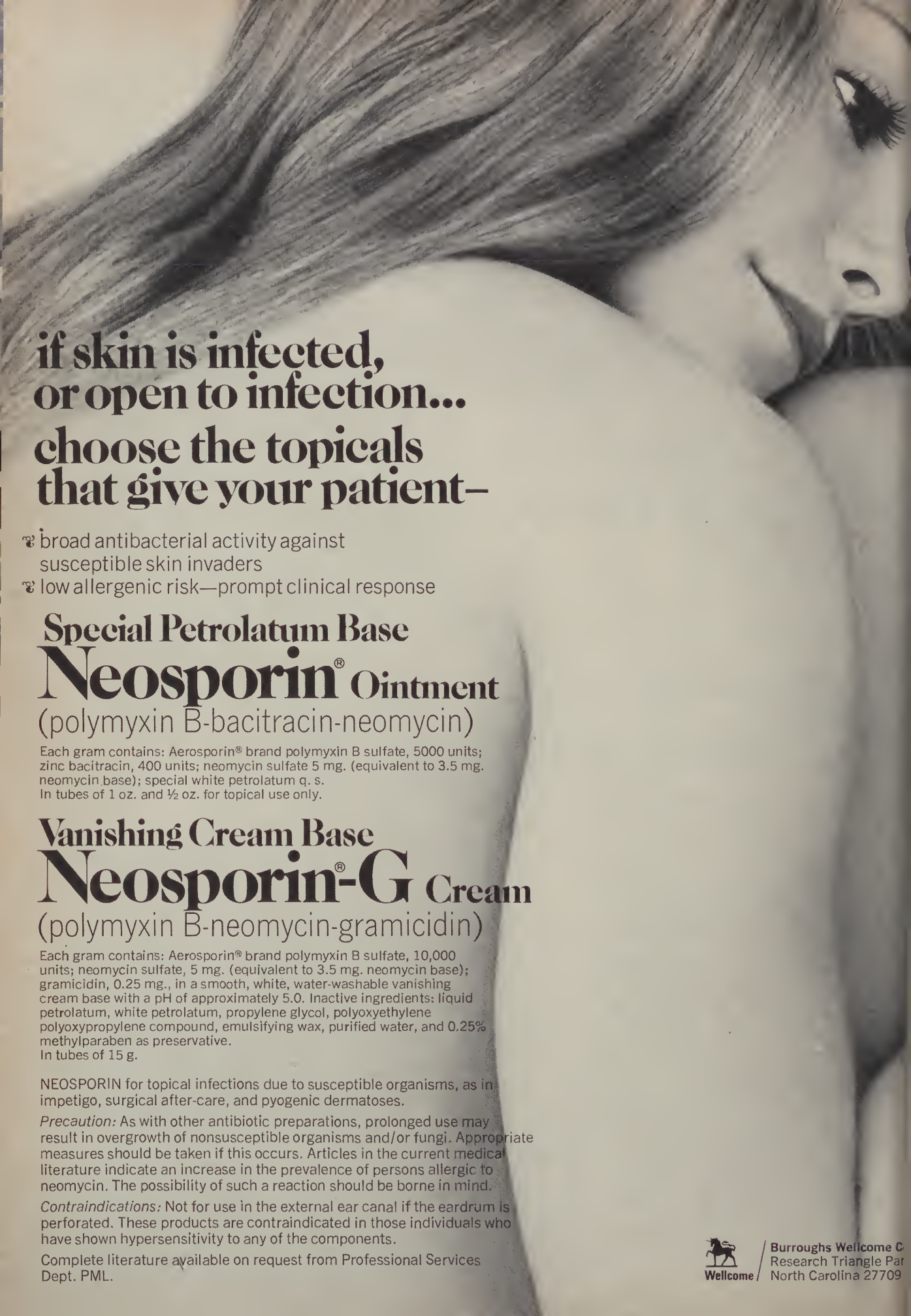
## Robinul® 2mg. Forte (glycopyrrolate)

**INDICATIONS** Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with the episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic cholelithiasis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure spasm, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital is indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 16.2 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Other side effects associated with the use of anticholinergic agents include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one to three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum needed to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved with AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

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Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

**Vanishing Cream Base**  
**Neosporin<sup>®</sup>-G Cream**  
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.  
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

*Precaution:* As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

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SEE PAGE 52 FOR APPLICATION FOR SCIENTIFIC EXHIBITS

John B. De Hoff, Md., Chairman  
Committee on Program and Arrangements



An epidemic that's striking home...

# gonorrhea

There were over 14,000 reported cases of gonorrhea in the Old Line State last year... 75 percent of them in Baltimore alone

In Maryland...and everywhere else...  
a new alternative

**NEW** **Trobicin**<sup>®</sup> **SPECTINOMYCIN**  
**DIHYDROCHLORIDE, PENTAHYDRATE, UPJOHN**

**single-dose treatment for  
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a chemically distinct antibiotic indicated specifically  
for treatment of acute gonorrhea:

in the male—acute urethritis and proctitis

in the female—acute cervicitis and proctitis

when due to susceptible strains of *N. gonorrhoeae*

**High cure rate:**\* 96% of 571 males, 95% of 294 females  
(Dosages, sites of infection, and criteria for diagnosis and cure are defined on page 3 of advertisement).

---

**Assurance of a single-dose, physician-controlled treatment schedule**

---

**No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed**

---

**Active against most strains of *Neisseria gonorrhoeae* *in vitro* (M.I.C. 7.5-20 mcg/ml)**

---

**A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour** (average serum concentrations of 15 mcg/ml present 8 hours after dosing).

---





NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up or at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.



# Trobicin and the gonorrhea challenge

## An accelerating epidemic— a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection—and it should not demonstrate cross-resistance with penicillin

## Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

## High cure rates: 96% of 571 males, 95% of 294 females

Clinical Results with Single-Dose Treatment, Intramuscularly\* (Data compiled from reports of 14 investigators\*\*)

	Dosage	Number of Patients	Number Cured	Percent Cured
<b>Adult Males:</b> Gonorrheal urethritis	<b>2 grams</b>	<b>475</b>	<b>457</b>	<b>96%</b>
	<b>4 grams</b>	<b>96</b>	<b>93</b>	<b>97%</b>
<b>Adult Females:</b> Gonorrheal cervicitis	<b>4 grams</b>	<b>294</b>	<b>280</b>	<b>95%</b>

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluable and were not included in the table above.

No allergic reactions occurred in patients with an alleged history of penicillin hypersensitivity when treated with Trobicin, although penicillin antibody studies were not performed.

## Chemically distinct

Trobicin is structurally not related to any other antibiotic commonly used to treat gonorrhea.

## The assurance of a single-dose, physician-controlled treatment schedule

Intramuscular injections should be made deep into the upper outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrheal urethritis. Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in gonorrheal proctitis and in patients being re-treated after failure of previous antibiotic therapy. In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams intramuscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in acute gonorrheal cervicitis and proctitis.

Safety for use in pregnancy has not been established, nor has safety for use in infants and children.

The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

\*4-gram doses were injected in two gluteal sites.

\*\*Medical Research Files, The Upjohn Company



a chemically distinct antibiotic indicated  
specifically for treatment of  
acute gonorrheal urethritis and proctitis in males  
and cervicitis and proctitis in females  
when due to susceptible strains of *N. gonorrhoeae*

# new **Trobicin®**

STERILE SPECTINOMYCIN DIHYDROCHLORIDE  
PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

## **Sterile Trobicin®**

(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injection: 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

**Warnings:** Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

*Safety for use in infants, children and pregnant women has not been established.*

**Precautions:** The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

**Adverse reactions:** The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25°C and use within 24 hours after reconstitution with diluent.

*Male*—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic re-

sistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

*Female*—single 4 gram dose (10 ml) intramuscularly.

**How supplied:** Vials, 2 and 4 grams —with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

*Susceptibility Powder*—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

**Human pharmacology:** Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

*For additional product information, see your Upjohn representative or consult the package insert.*

MED-B-1-S (LWB)

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001





MORRIS N. KOTLER, MD, EDITOR

*A Service of the Heart Association of Maryland*

## the heart page

# Radionuclides In Clinical Cardiology

MALCOLM COOPER, MD  
Department of Nuclear Medicine  
The Johns Hopkins Hospital  
Baltimore

Radionuclides were first used in studies of circulation 45 years ago when Blumgart and Weiss, using radium-C, measured the velocity of blood flow and the pulmonary circulation time.<sup>1,2</sup> Since then, advances in the field of nuclear medicine accompanied by the rapid growth of nuclear medicine departments have made many techniques employing radionuclides available to clinical cardiologists. Developments in instrumentation have made an important contribution to growth of the specialty.<sup>3</sup> The Anger scintillation camera makes it possible to portray the passage of gamma-emitting radionuclides flowing through the circulation. Quantification of the data making up the images can be achieved by interfacing the camera with a computer.

The discovery and increasing availability of short-lived radionuclides has led to the development of many useful new radiopharmaceuticals. Certain radionuclides can be obtained from a generator system in which a long-lived parent radionuclide bound to an inert support decays to produce a short-lived daughter radionuclide of a different element. The daughter element is readily separated from the bound parent. Sterile, pyrogen-free radiopharmaceuticals can be made quickly available whenever the clinical need arises and this is facilitated by the use of radiopharmaceutical "kits" to label compounds.

Lung scanning is the most widely used radioactive tracer study in clinical cardiology today (Figure 1). Its use in humans was first described in 1963 when macroaggregates of human serum albumin were labeled with radioactive iodine (<sup>131</sup>I-MAA).<sup>4</sup> Indium-113m

and Technetium-99m, short-lived radionuclides with physical half-life of 1.7 hours and eight hours respectively, have many advantages over the use of iodine-131.<sup>5</sup>

Lung scans depict the relative distribution of pulmonary arterial blood flow.<sup>6</sup> The probability of a scan defect being due to pulmonary embolism is high when the defect involves segmental or lobar arteries. Reduction or absence of perfusion to a whole lung occurs much less frequently. Multiple views (anterior, posterior, and both laterals) of the lungs are required for adequate characterization of lesions. It is necessary to be able to exclude other disorders such as pneumonia, chronic lung disease, congestive heart failure, and bronchial asthma. Radiospirometry and regional ventilation measurements using inhaled <sup>133</sup>Xenon gas have proven useful in distinguishing emphysema from pulmonary embolism.<sup>7</sup>

Lung scanning has been instrumental in increasing our understanding of the natural history of pulmonary embolism, and has been of value in assessing the effectiveness of thrombolytic agents such as urokinase and streptokinase.

Radioisotope scanning in the diagnosis of pericardial effusion is also an established procedure.<sup>9</sup> A promising development is the use of radioisotope angiography in the diagnosis of congenital heart disease and in distinguishing various types of congenital cardiac abnormality which produce cyanosis in the newborn.<sup>10,11</sup>

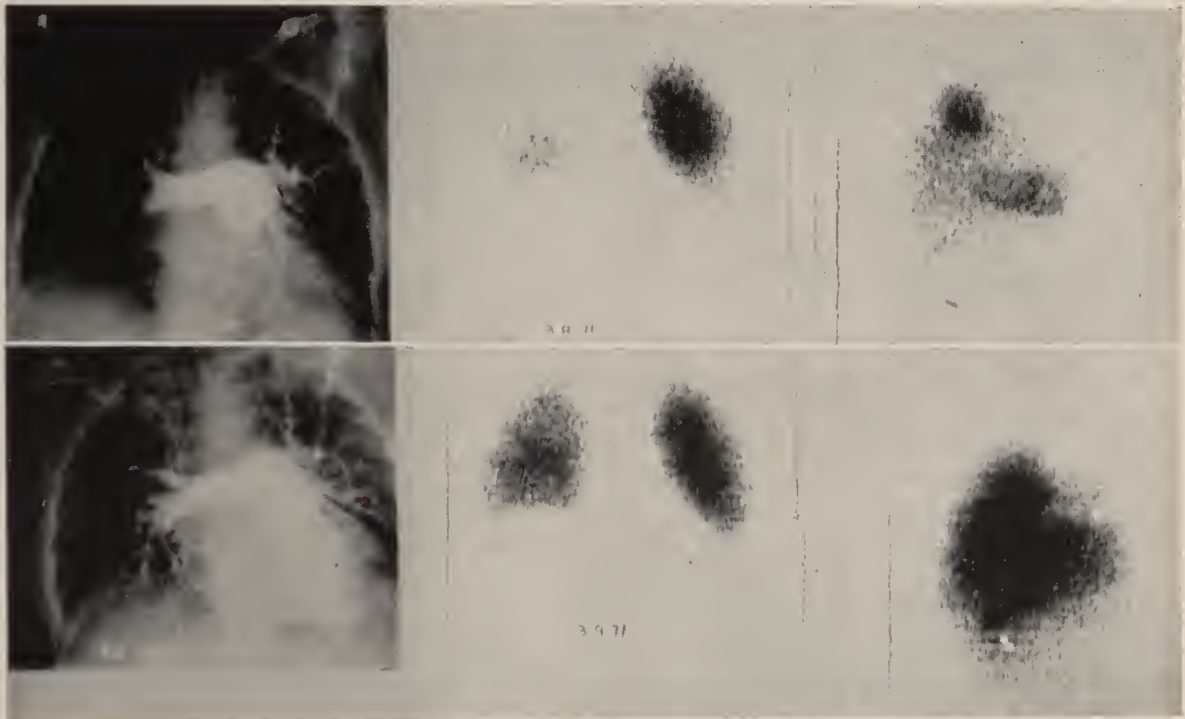
This technique can also be used in acquired heart disease, especially for studies of patients with mitral stenosis or mitral insufficiency.<sup>12</sup>



The systolic and diastolic volumes of the left ventricle can be measured when the Anger camera is used with an ECG gating system and a radiopharmaceutical which remains within the vascular pool.<sup>13</sup> Further developments of this method provide measurement of the left ventricular ejection fraction and allow the detection of dyskinetic areas of the left ventricular wall.<sup>14</sup> The noninvasive nature of radioisotope methods make them particularly suited for use in acutely ill patients. Their role in monitoring left ventricular performance following myocardial infarction appears promising.

There has been a recent upsurge of interest in myocardial scanning although it is nearly ten years since Carr, et al, first used rubidium-86 for

this purpose.<sup>15</sup> Use of the newer isotopes potassium-43 (<sup>43</sup>K) and cesium-129 (<sup>129</sup>Cs) has been responsible in part, along with improved instrumentation.<sup>16,17</sup> The realization that neither coronary care units nor mobile care units have made a significant reduction in community mortality from myocardial infarction has emphasized the need to identify the susceptible individual. Initial studies with <sup>43</sup>K and <sup>129</sup>Cs appear promising for detecting both the location and extent of a myocardial infarction.<sup>18</sup> It seems predictable that myocardial scanning will assume an increased role in the future as a screening test and in the acute and follow-up care of patients with coronary heart disease.



**Figure 1: Pulmonary embolism** (Upper) Pulmonary arteriogram with anterior and right lateral views of lung scan; (Lower) Repeat study following 24-hour infusion of thrombolytic therapy.

The initial lung scan shows reduced or absent perfusion in the right lung except for the apical-posterior segment of the right upper lobe. Perfusion is diminished to the right middle lobe and part of the left lower lobe. Return of perfusion to the affected areas is seen in the followup scan. The diagnosis of massive pulmonary embolism was confirmed by pulmonary arteriogram.



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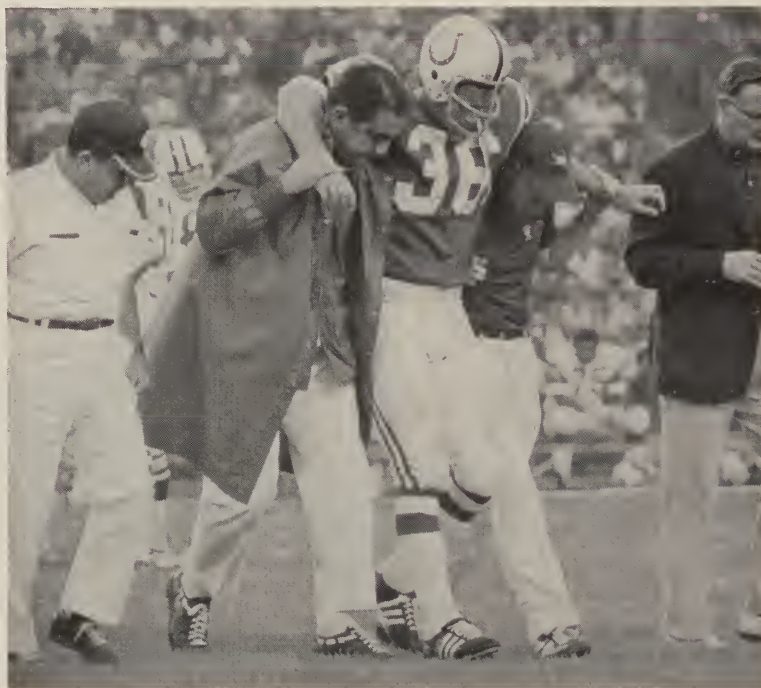
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# SPORTSMEDICINE

**The papers that follow were presented at the Fourth Annual Seminar on the Medical Aspects of Sports held in December 1970 at the Catonsville Community College in Catonsville, Maryland. The Seminar was sponsored by the Medical and Chirurgical Faculty of the State of Maryland and the Division of Health, Physical Education, and Recreation of Catonsville Community College.**

**Reservations are now being accepted for the Fifth Annual Seminar (same sponsors, same location) to be held on December 4, 1971.**



SPORTSMEDICINE? Baltimore Colt Norm Bulaich is helped off the field by two trainers (they will take part in the December 4 Seminar) as Edmond J. McDonnell, MD, orthopedic surgeon and also a Baltimore Colts team physician, leads the way.



# Stress Limits in the Young Athlete

ELSWORTH R. BUSKIRK, PhD

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Institute for Science and Engineering

The Pennsylvania State University

University Park, Pennsylvania

If interactions of the body with various environmental factors are considered, it is apparent that we live in a complex world. Nutritional, parental, peer, and other personal and environmental influences have an important impact on the growing and developing child.

We do not have the tools to determine whether exposure to rigorous activity produces measurable effects in the very young who cannot be tested in conventional ways. It has been demonstrated that early overnutrition can influence the number of adipocytes and hence the propensity to obesity. Similarly, early undernutrition or malnutrition may influence eventual intellectual capacity. Thus, there is the intriguing possibility that mature physical capacity is influenced by what happens very early in life, or from the time the infant is capable of playing. Muscularity, bone density and erythropoietic activity, and muscle vascularity may have development rates that are dependent on physical activity as well as other environmental factors.<sup>15,16</sup>

In the functional fitness or physiological capacity examination of boys and girls, it is apparent that large interindividual differences can be found and that these differences are highly dependent in normal children on their state of physical condition.<sup>1,2,13</sup> Work and aerobic capacity is increased by physical conditioning and training.<sup>14</sup> Similar development can occur in strength, speed, and endurance.<sup>10,13</sup> The question remains as to what effects prepubertal conditioning and training have on the organism in terms of growth, maturation, and development. Appropriate studies have not been conducted. It may well be that capacity later in life is at least partially dependent on conditioning or training early in life.

Of particular concern are various physiological considerations, primarily those

related to cardiorespiratory fitness and capacity. A large proportion of past experimental work has simply compared the physiological responses of those who differ markedly in fitness and work capacity, ie, those who are sedentary compared with athletes. This approach bypasses genetic considerations. These are probably as important as formal conditioning and training. A child may well tend to participate in sports because of an inherited potential that is greater than that of his contemporaries. Inheritance may also influence the response to conditioning and training.

Physical conditioning involves the general physiological process of stress adaptation. The studies of Hettinger and coworkers<sup>8</sup> on strength development reveal the following concepts related to optimal adaptation to stress:

1. must exceed intensity and duration threshold to achieve optimal rate and amount of response — intensity may be relatively more important than duration
2. continuous exposure facilitates adaptation
3. intermission allows some deadadaptation to occur which may be physiologically beneficial

The relative importance of frequency, intensity, and duration of conditioning and training must be established by direct experimental work. Coaches do this in an empirical way, and we have seen their astounding age group performance results in young children, particularly in swimming and track.



Fitness is specific to the task to be undertaken and this includes athletics. Techniques, skills, conditioning, motivation, and gamesmanship are interwoven into the mosaic that is athletic competition. To say that all athletes do not require high level cardiorespiratory fitness is correct, but attainment of this fitness gives them a competitive edge in many sports.

### Performance

There is little need to cite the performance record in age-group activity. We are still aware of the teenage girl world record holders in swimming. Those in their teens have reached the world class stage in practically all sports except those requiring extreme endurance or exquisite skill that only years of training and experience can produce. Inspection of an *AAU Guide* or a specialty publication such as *World Swimming* reveals the premier physical capabilities of well-trained and conditioned children.

Just as the menstrual cycle taboo against competition for post-pubertal girls and women has been overcome, so has the taboo against dedicated training and conditioning for children. If the environmental climate is satisfactory, ie, no over-pressure from parents, coaches, or teammates, then the results of dedicated preparation by children for competition apparently produces no measurable adverse effects. However, the research base for this statement is indeed meagre.

### Strength

The results of most maximal strength tests in children are significantly correlated with skeletal age. Depending on the muscle groups and joints tested, the correlation coefficients range from 0.35 to about 0.80. In upper elementary and junior high school boys, the mean total body strength of the athletes and regular intramural competitors was significantly higher than the means for nonparticipants although the active boys did not necessarily exceed the inactive ones in skeletal age and pubescent development. Considerable interindividual variation was present.<sup>6,7</sup>

### Cardiovascular

Good data are not available to describe the central cardiovascular events for preadolescents and adolescents. What has been identified is the fact that children have a higher maximal heart rate (HR max) than do young adults. HR max for children from eight to ten years of age is about 205 to 210 compared to 185 to 190 for 20- to 25 year old men.

Preliminary work shows a lower cardiac output (Q) and stroke volume (SV) and a higher arterial venous oxygen ( $a-vO_2$ ) difference for a given oxygen consumption ( $Vo_2$ ) in children as compared to young adults. Girls' aerobic capacity ( $Vo_2$  max) is slightly lower (about 10-15%) than that for boys. This difference increases during late adolescence. It is interesting that  $Vo_2$  max per unit of total body weight does not change appreciably from age six to 17.

During the submaximal work the HR of adolescent girls is higher than that of boys. For a given task the girls work at a higher percentage of their HR max and  $Vo_2$  max. Maximal Q, SV,  $a-vO_2$ , and arterial oxygen content appears to be lower in adolescent girls than in boys. The lower Q max and SV max may be due to the smaller heart volume and plasma volume.<sup>3, 4, 14</sup>

### Diffusion Capacity

In terms of oxygen transport, the transfer factor for carbon monoxide (CO) is increased in a linear fashion with the increase in cardiac output (Q). In well-conditioned adolescent swimmers, the CO transfer factor was higher at rest and at  $Vo_2$  max than in unconditioned young men.<sup>1</sup> In the latter group, the CO transfer factor levelled off at 70%  $Vo_2$  max but did not do so in the swimmers. The swimmers reached a higher  $Vo_2$  max, Q max, and SV max. The swimmers' heart rate was somewhat lower at all metabolic levels.<sup>1</sup> The greater CO transfer function implies a larger surface area for diffusion across the alveolar-capillary membrane or a possible greater perfusion brought about by greater capillarization of the alveoli or both.

### Joints

There is a wide discrepancy in the size, maturity, and coordination of boy athletes who participate in Little and Pony Leagues in baseball. Boys in the age range eight to 15 who participate as pitchers are susceptible to the traction strain of the pitching movement. Shoulder and elbow pain usually signify epiphyseal problems. Football passing, the tennis serve, and similar arm and shoulder actions in sports, expose athletes with open epiphyses to joint damage.

### Other

A cursory review of the literature revealed little quantitative or qualitative information about muscle and its structural or compositional changes with conditioning and training in children or in group differences identifiable with habitual participation in one sport or



another. There may well be changes or differences in muscle tissue induced by chronic physical activity. The animal literature would suggest as much. Comprehensive data on children are not available. All we know is that the child athlete has been identified as being relatively more muscular than his more inactive counterpart.

Discussion has been bypassed of the stress limits imposed by heat, cold, hypoxia, semistarvation, and hypohydration on the young organism. There is some evidence that the stress limits may be lower for children than adults and that there is a relative increase in associated physiological strain (compared to the adult) in response to a fixed stress. Unfortunately, experimental results that can be conclusively discussed are unavailable.

### Age Range

Growth and development studies of children indicate increased height, weight, and muscularity during the 1940s, 50s, and 60s. A levelling off has not yet been achieved.<sup>11,15,16</sup> Subjective appraisal over the years of schoolboy athletes at track and swimming events appears to substantiate this observation. Although world records are set by these child athletes who appear larger year by year, these youngsters may not be fully mature. Although they do not possess the sheer strength of older athletes,

they do produce winning performances. An explanation is not readily apparent. Further research is needed. An important factor, no doubt, is that their aerobic capacity per unit fat-free body weight equals adult values.<sup>4,9</sup> To establish perspective, perhaps the trend is not only to younger world class athletes, but to older ones as well. Thus, the competitive age range may be widening. To some extent conditioning and training offset the deterioration in physical performance commonly identified with aging.<sup>5,14</sup> A George Blanda or Hoyt Wilhelm (both in their 40s) offers small consolation to the younger opposition.

### Summary

The breadth of competition has increased in recent years to include youngsters who can be clearly labeled world class athletes. These children engage in conditioning, training, and competition at a stress level regarded as impossible only a few years ago. There is little evidence to suggest that the resultant physiological strain does irreparable damage. Unfortunately, the physiology of these youngsters under stress has only been partially studied. Differentiation among genetically and environmentally induced changes has only begun. The performance of man frequently exceeds our understanding of that performance. The record book for the child athlete has, if anything, widened the knowledge gap.

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# Sports and Physical Fitness Programs for Girls of Western Europe Compared With Those in Maryland

MRS. RANDALL C. COLEMAN

Member, Maryland State

Commission on Physical Fitness

While so much emphasis in physical education is on the training of male athletes to represent their schools in competitive sports, let us spend some time here thinking about the female half of the school community — the girls who are preparing in high school for their future lives.

These girls are planning to go to college, into the business world as secretaries or office workers, or into a technical trade. Almost all are planning ultimately for marriage. A few are interested in making the girls' basketball team, or in swimming on their own for a team in the summer, but the large majority will probably never be on a school team.

Those who are interested in active athletics will probably take care of their own physical condition. But for the others, their physical education exposure in high school will be the foundation of their life-long understanding of the need for exercise: proper posture, the basic health of good digestion, relaxed sleep, healthy cardiovascular and respiratory systems, endurance, energy, and muscle strength. These girls are *your* daughters, *your* wives, *your* mothers, or maybe even *your* mothers-in-law. You want them looking good and in good health so they can do the housework, chase the children all day, mow the lawn for you, and still greet you at the end of the day slim and full of energy.

What kind of program in the high schools is going to educate the most girls the most effectively? Several typical high schools that I visited in Europe in November 1970, including public schools for girls in Greater London, Oslo, Copenhagen, and Hamburg, have interesting answers to this question.

Few gymnasiums in Europe can compare with the standard facilities in our modern big-city high schools. Most are the size of one, or possibly two badminton courts. In most, the ceiling is too

low for our game of basketball. Apparatus is sometimes old or makeshift, but it is a major physical education activity. Swimming pools are the exception in most of Europe. Locker rooms vary from good to nonexistent. Showers are not usual, especially in the older schools. But none of these situations is considered a deterrent to an active physical program.

In every single gym I saw there was a record player. In the new schools, a built-in compartment with record player, amplifier, and tape deck is standard equipment. This can be the most valuable piece of equipment for any gymnasium.

The schools use outside facilities quite freely for their own programs. One school rents space from a private club next door. Children are bussed to outside ice rinks, playing fields, or swimming pools if they have none at their own schools.

The Crystal Palace National Sports Center, built by the Greater London Council (at a cost of 2.75 million pounds, or approximately \$6.6 million), represents an ideal civic sports arena. London suffers from the same congested downtown crowding as does Baltimore. There is neither money nor space to build complete gymnasium facilities for every school. The Crystal Palace utilizes many acres in an accessible location to centralize a wide range of athletic facilities. There are three swimming pools, one of which is a 50-meter olympic pool, a soccer/football field with grandstand, two tracks, dozens of table tennis tables, and three enormous gyms. It is used for national and international competition, for seminars for teachers and coaches, and is also available for the use of the public schools. Children come from all over London to learn squash, judo, badminton, soccer, and springboard diving. This huge complex is also open to the general public for a very moderate entrance fee. Since its opening in 1964,



2.5 million people have actively participated in the sports to which it caters.

Have our congested big cities considered central athletic facilities to solve the problem of lack of space and lack of funds in our urban high schools?

In England as in our schools, sports and skills are taught with a goal of preparing the girls to enjoy various games and sports in adult life. They are fortunate in having three hours per week for physical education. (Baltimore requires only two.) One of these hours is devoted to sports, and of a surprising variety, as for instance in the county of Surrey, south of London.

Athletics, badminton, basketball (not the same as in the U. S.), cricket, gymnastics, hockey, lacrosse (only girls play lacrosse in England), lawn tennis, netball, national rounders, orienteering, roller skating, sailing and canoeing, skiing, trampolining, swimming, and table tennis are taught.

Inter-school competition in all these sports extends down through four or five teams if necessary so that all interested players can compete. In addition, there are active after-school "clubs" and private associations open to students as well as adults for competitive training. These clubs often rent the school facilities, and often hire the school faculty as coaches.

This independent athletic club system is a vigorous well established tradition in Europe. It is interesting to see growing public pressure for use of school facilities in the United States after school hours. And it is also interesting to think of the athletic department as being more concerned with teaching athletics than with maintaining a championship team in order to keep its job.

In Scandinavia and Germany, the school system teaches almost no sports. For one thing, they do not have sufficient facilities. Secondly, sports are taught in the separate club system. The physical education teacher uses her time to present a strenuous non-competitive program of individual exercise. An ideal class (a girls' high school in Copenhagen) may be described as follows:

The teacher used taped music — light-hearted folk music, some American folk-rock, and some classical music. She started the class promptly, leading the girls in running in a big circle, running in place with emphasis on exercising the arches of the feet, some elective creative movement, some yoga, some modern dance, some frug, some African dance, a little classical ballet, and

some good old-fashioned setting-up exercises. Her purposes were relaxation, flexibility, muscle strength, rhythm, balance, coordination, grace, posture, and endurance. The good things about this class were that there were no teams to choose, no girls knowing that nobody wanted them on the relay team, no rules to explain or long instructions to give, and no waiting in line. Because all the girls were busy all the time they had no time to be self-conscious, or to notice who was clever or who was awkward. And the continuity of the program from day to day was such that there was no need for lengthy instruction. The teacher taught by example. At the end of the class, as a special treat, there was some basic work on the apparatus. By the end of the class the girls were happily exhausted and in high spirits as they hurried to change for their next class.

The teacher expressed great pride in being an ideal for her girls to strive for. She felt a responsibility to use every minute of her class time in active exercise. She was attractively dressed, well-groomed, vivacious, in superb physical condition, and — above all — feminine. I might say parenthetically that she had taught three classes that day, but just for fun, she and her husband had run five miles before school that morning. Her classes were so popular that she had volunteered to have one for the faculty as well. Again parenthetically, another teacher I talked to had persuaded his own wife to conduct a class in the school gym for the mothers of the pupils in the school. (This class is now in its eleventh year.)

Now this was a stimulating class for the girls who could keep up with the teacher. But what about the girls with lesser endurance, ability, or motivation? The teacher said she never commented when a girl failed to perform a particular exercise. She never singled anyone out for criticism or told anyone to do anything over. The girls who could do only two sit-ups did only two. When I asked her about this after the class, she said she always assumed they were doing the best they could, and that only the girls themselves could judge their own capabilities. But one must think that the cheerful music, dance-like quality of the exercises, and this teacher's graceful movements and beautiful figure must surely be an inspiration to each girl.

Weight-lifting was sometimes included as part of the program for girls, and for a surprisingly simple reason. In a few years, these girls will be lifting the baby out of the play pen, lifting the baby carriage up the front steps, and carrying in the groceries. They are learning that *proper*



lifting methods will help prevent back strain in later years.

Another teacher demonstrated relaxation methods. Twenty-five girls lying on the floor are instructed in systematic relaxation of major muscle groups in a routine that takes about seven minutes. What a useful thing to know in later years to cope with the tensions of raising children, or of office work!

This kind of class requires a *good* teacher. She's got to be able to *do* all the things that she teaches — through several classes a day. And she must have a thorough professional knowledge of the physiology of what she teaches. And she's got to know that her students respect her. But she requires only the simplest equipment — possibly just mats and some source of music. And she needs so much less space than for most sports.

I saw this type of class poorly run in another school in Europe. The teacher was attractive and young and the girls obviously liked her. But the weakness in her class was obvious. She had the girls line up in groups to take turns, and those who were not busy either lost interest or giggled about the girls who were performing. And the standing around time was lost time — so precious when there are only two or three periods a week. And, what seemed most significant, the teacher described rather than demonstrated. She herself was not an example. In this particular class over one third of the class of 25 were "sitting out." There will always be some girls who must be excused, whether it be for menstrual period, bad cold, or injury.

Generally, in Europe, the girls are encouraged to do rather than not to do. For instance, my guide in Norway told me that they encourage the girls to participate during menstrual periods, and the girls find that they feel *better* for having the exercise. They report that they have less cramps, depression, or lassitude. And in this non-competitive atmosphere they can do just as much or as little as they feel like doing. The teachers encourage them to "just get dressed and start with us." And then the girls find that the class is so much fun that they don't want to be left out. There seems to be a correlation between a busy, entertaining class and high attendance. A dull class and a lot of standing around lead to poor attendance which leads to a duller class because so many girls have fallen out of the routine.

Testing is not very important in the schools with this kind of class. Just as the atmosphere is non-competitive in the sense that there are not teams to make or objective performance goals to

achieve or fail to achieve, there are, in most cases, no grades to compete for. This saves the teacher a lot of time in computing grades. She is spared the ordeal of comparison of performance in class, as affected by all the variables of natural aptitude, attendance, possible illness or physical handicap, and previous training. Collation of this information, perhaps by the making of graphs and computation of standard deviation or other statistical "gymnastics" is also eliminated. Testing time can be better used for teaching time, and physical education remains an island of joy in the academic stresses of the day.

Physical education teachers find a great deal to admire in the United States. They tremendously admire our facilities. They recognize a trend to follow the lead of the United States. There is pressure for standardization of the curriculum and for standardized testing. At present, research is being done to set up a grading system in Norway. Most of the teachers expressed a need for more competitive sports in the schools. And some inspectors were concerned over the lack of proficiency in some teachers.

There is concern in all of the cities that I visited that the time spent in physical education is being diminished. In Scandinavia just this past year, it has been cut from three hours a week to two. A great public information campaign has been launched by the teachers themselves who, instead of being pleased to be relieved of the extra work, are concerned that the students will miss the needed exercise. They see the growing affluence of the people, the declining use of bicycles in favor of motor bikes and cars, the spread of TV, and the replacement of manual work by machines. They are aware that these influences lead to poorer physical condition in boys and girls, and they anticipate the same problems that we face in the United States as their own living standards catch up to ours. And we are aware that our teenagers are not performing up to satisfactory levels on world-wide tests of physical condition.

The more sedentary our teenagers' lives become, the more our schools need a program of vigorous, pleasant, non-competitive, rhythmic-based exercise for our teenaged girls to complement the sports and games they learn. Teach girls in high school to enjoy vigorous exercise, to know the pride of good posture and graceful movement, and to use the energy provided by a strong heart and lungs. They are your daughters and your wives, and you want them to stay in good health and looking good for all of their adult lives.





## CALORIES / 7 oz. Serving\*

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Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
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Cream of Potato	58	Green Pea	116
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# The History of Birth Control



## After a 4,000-year search, have women finally found freedom?

Abortion and infanticide have, throughout history, been the final and desperate resort of women who were unable to control their fertility, but for almost 4,000 years they have sought ways to prevent conception.

In ancient Egypt they used pessaries of crocodile dung or tried to clog the motile sperm with honey and a gumlike substance. The women of Islam used tampons of pomegranate pulp and rock salt. In Japan they burned little balls of "burning grass" on the *mons veneris* or, more practically, tried to cover the mouth of the uterus

with disks of oiled bamboo tissue paper. In the 18th Century in France upper-class women rediscovered the vaginal sponge, a device mentioned in sources as old as the Talmud.

It may seem now that such advances as oral contraception and the IUD have freed women from this often fruitless search and consequent suffering, but there are millions of women in the United States and elsewhere who have less knowledge of, and less recourse to, contraception than Egyptian women of the Twelfth Dynasty. Nothing is more urgent to all of us than to bring them help. We cannot long support the ecological pressures of an additional 70 million Earth inhabitants each year.



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**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study of Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because

these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

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# Field Diagnosis of Athletic Injuries

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Orthopaedic Surgeon

Team Physician

University of Maryland

Diagnosis is derived from the Greek word "gignoskein" meaning to know. It is defined as the process of determining by examination the nature and circumstances of a condition and the decision reached from such an examination.

Actually, when confronted with an injury during a game, one must rely more upon an impression based on single or multiple symptoms. Therefore, the decision derived must be based on knowledge and experience. Fortunately, interest in sportsmedicine has steadily increased so that one may attend seminars such as this in almost any region of the country.

Clinics established by committees of the American Medical Association, the American Academy of Orthopaedic Surgery, the College of Sports Medicine, and local medical societies are being held constantly. Through dissemination of experience of others, we can profit with the direct result being better medical care for the athlete. Errors in judgment will still occur but with decreasing frequency and severity.

How nice it would be to have instant replay not only of the injury but its management. We could then alter our decision until 100% correct.

Before proceeding to specific injuries, let us discuss four basic principles to be followed on the field.

The first is to render immediate lifesaving treatment such as establishing an airway and other emergency first aid dictated by the condition of the player.

The second is to obtain a history of the exact mechanism of injury. Did it occur blocking, tackling, "spearing," twisting, etc?

The third is to examine the player thoroughly, unhurried because of timeouts, officials, coaches, or restriction of any piece of equipment. The examination must include accurate localization of the injury, determination of loss of function and stability and palpation for tenderness, swelling, and deformity.

The rule charging a team with a time-out if an injured player is unable to leave the field has aggravated many injuries and should be abolished, especially prior to the last two minutes of a half or game when there is no reason to feign an injury in order to stop the clock.

The fourth principle is to distinguish those injuries which contraindicate further participation and those which would not be aggravated by playing.

We have all been taught to treat diagnosis and not symptoms. This is fine in the office or at the bedside, but is not always realistic on the field.

Field diagnosis of athletic injuries may be more accurately described as symptoms associated with injuries and the management of those symptoms. The growing high school athlete is prone to certain injuries not seen in the adult. It is important to be aware of this in order to recognize and institute proper management. If overlooked for any reason, permanent disability and deformity may result from an otherwise insignificant injury. Growth



plates, technically referred to as epiphyseal plates, are those areas by which bone grows. Being weaker than the adjacent ligament, they are subject to dislocations, avulsions, and fractures.

The little league pitcher will develop widening of his growth plates. After seeing many pitchers from 16 to 18 years of age with painful shoulders and elbows, I feel little league baseball should be withheld until age 12. This may account for the scarcity of good major and minor league pitchers.

### Head Injuries

Head and neck injuries are increasing every year. A recent article recommending removal of the face guard merits serious consideration and further statistical evaluation. Spearing, the act of striking an opponent with the helmet, is illegal but still seen week in and week out in spite of massive dissemination of literature warning of the injuries to the head and neck as a result of this practice. Anyone who has seen Dr. Schneider's movie, vividly demonstrating the complications of spearing, would never again encourage its use.

An unconscious athlete presents a challenge in diagnosis and management. Vital functions must be restored. Examination includes checking the pupils, noticing bleeding from the nose or ear, and checking the response to pain. The player must be removed by ambulance to a hospital for further evaluation. If only temporary, although apparently fully recovered, he should not be permitted to return to the game. Headaches, dizziness, and visual or ear disturbances require further evaluation and observation. This then is actually an easy problem since there is little question as to correct management. Ironically, this is true of all injuries. That is, the more severe the injury the easier the decision as to what to do about it.

### Concussion

The classification of concussion by the American Medical Association committee is an excellent guideline. Do not forget the possibility of heat stroke in the disoriented or unconscious player. Death may occur even more rapidly than from a head injury per se. The temporarily dazed and disoriented player may return to the game if recovery is prompt and void of any neurologic abnormalities, headache, or amnesia for either present or past events.

### Neck Injuries

Neck injuries are among the most difficult to diagnose accurately and may produce the most morbidity. The problem is to distinguish between a fracture, dislocation, sprain or "nerve pinch". This is actually accomplished by exclusion. If the player falls to the ground with severe neck pain, numbness of one or more extremities, weakness or paralysis, a fracture or dislocation should be foremost in your mind. This is especially true if the pain is centered over the vertebra per se and associated with restricted motion and muscle spasm.

Nerve pinch, stretch, or compression present a difficult clinical picture. The mechanism of injury is a blow to the shoulder and neck with the head flexed and rotated to the contra-lateral side. This player will run off the field dangling his arm by his side complaining of numbness, weakness, and even paralysis of the extremity. There is also a burning pain in the area of the trapezius. Active motion of the neck may be normal without bone tenderness. If in doubt, the player should be held out pending further evaluation.

### Chest Injuries

Injuries to the chest may include not only fractured ribs but also — and even more important — trauma to underlying structures such as the lung, heart and, yes, even liver and spleen. In the presence of pain, tenderness, and restricted breathing the player must be removed and evaluated further. If signs of shock are present he should be rushed to the hospital.

In a blow to the abdomen—the solar plexus syndrome—where the player has severe pain, trouble breathing, and numbness in his legs, close observation is required. Once fully recovered, he may return to the game. The possibility of a ruptured organ must be considered especially if examination initially reveals a soft abdomen which becomes more rigid and painful as peritonitis develops or shock ensues.

Shoulder pain presents a problem in diagnosis since it may be caused by neck injuries as well as ruptured viscera. Let's consider the more common problems.

Semantics is important in shoulder injuries. Shoulder separation is used when referring to the acromioclavicular joint and shoulder dislocation when discussing the glenohumeral joint.



## Shoulder Problems

A fall on the shoulder will produce pain and tenderness at the acromioclavicular joint. A minor or Grade I sprain is not associated with tearing of the coracoclavicular ligaments. There is therefore no palpable deformity. This requires symptomatic treatment and the player may play. A Grade II or III tear will produce a palpable and visual deformity and surgery may have to be considered. In spite of the obvious deformity, this injury is frequently overlooked.

The dislocated shoulder, if complete, reveals the characteristic deformity of a hollow in the deltoid, restricted motion, and pain. Thorough neurologic examination of the brachial plexus is imperative as are appropriate X-ray studies prior to reducing. An X-ray showing the exact nature of the dislocation, especially the first time, will be beneficial in planning corrective surgery later. An initial dislocation must be immobilized at least three weeks unlike the recurrent cases where the player may be allowed to return to the game. In discussing shoulder injuries, always keep in mind the dislocation of the medial end of the clavicle from the sternum. If posterior, this requires immediate reduction. The findings are pain, tenderness, and deformity. Unless the equipment is removed, the diagnosis will be missed.

## Knee Injuries

Knee injuries consist of fractures, sprains, meniscal and ligamentous tears and, in the younger child, epiphyseal separations. First and foremost in evaluating a knee injury is allowing the player to tell you how it happened, what he felt, and where it hurts. This may be more important than the actual examination. It is then necessary to expose the joint for proper evaluation. Therefore, removal of stockings and pants is necessary. It is true we do not remove the player's pants on the sideline; however, if a serious injury is suspected the player should be removed to the dressing room where an adequate examination can be performed.

The pain may be posterior as in a hyperextension stretch, or over an attachment of the collateral ligaments or the joint line. Determine the presence or absence of ligamentous instability by examining in extension and partial flexion and compare with the "normal" knee since varying degrees of laxity are normal.

The range of active motion is important. Without instability it is possible to allow return to the game unless pain and swelling prohibits it. A meniscal injury may permit further participation depending upon the type of tear and its interference with joint function. Swelling must be evaluated fully before allowing further competition.

## Separations

Epiphyseal separations characterized by pain, tenderness, swelling, and instability on stressing occurs in the adolescent and should be kept in mind. I emphasize the importance of ligamentous evaluation. Stress is the keynote to any knee examination. It is the only way to diagnose a torn ligament and therefore must be performed on all knees. Unfortunately many kids are sent to emergency rooms where X-rays are taken and ace bandages applied. We must educate all physicians on the importance and technique of examining for ligamentous instability since the ultimate prognosis depends on its treatment.

Patella subluxation and dislocation must be differentiated from meniscus injuries. This is difficult at times, but very important.

## Ankle Injuries

Ankle injuries pose the problem of distinguishing the sprain, ligamentous tear, and fracture. Excepting ski injuries, the shoe, stocking, and tape should be completely removed. The mechanism of injury is considered and the pain localized. Obvious deformity, as with any injury, simplifies the diagnosis. If the pain is in the area of the fibulo-talar ligament, no instability, and bone tenderness or deformity, is present, the player may be strapped and allowed to play. If the pain is such that he is unable to participate, the ankle should be iced, wrapped, elevated, and evaluated with appropriate X-rays. These should always include the ankle and foot with stress films when indicated.

The prognosis of an athletic injury is directly related to the diagnosis and proper treatment of that injury. By programs dealing with athletic injuries, by continual research, by keeping better records, and by cooperation among physicians and trainers, we can reduce the frequency and morbidity of sports injuries. Programs to train high school students as trainers should be established throughout the country.



# Use and Misuse of Physical Therapy Modalities in the Treatment of Athletic Injuries

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In approaching the treatment of athletic injury, many questions need to be considered. Primary, of course, is the nature of the injury, its location and extent, and whether it is acute or at a later or chronic stage. Next, one must consider the desired effects of the therapy and the available modalities to achieve these effects. This decision includes the physical principles involved, the physiologic effects, and the potential dangers. Finally, there are the selection of the modality and the methods of application.

In classifying modalities, they may be grouped into thermotherapy, mechanotherapy, and therapeutic exercise. Thermotherapy may include the application of heat or cold (Table 1).

**TABLE 1**  
**THERMOTHERAPY**

<b>Cold:</b>	Relieve pain
	Limit bleeding, edema
	Ice massage Cold packs
<b>Heat:</b>	Relieve pain
	Relax muscle spasm
	Preliminary to stretching
	Preliminary to exercise
	Hot packs
	Whirlpool
	Paraffin Infrared Diathermy
<b>Diathermy:</b>	Short wave
	Microwave
	Ultrasound

These treatments are rarely indicated without subsequent use of one of the others, particularly therapeutic exercise, as shall be pointed out later.

Treatment with cold is usually restricted to the acute condition of soft tissue trauma to relieve pain and limit bleeding and swelling. Cold, in the form of ice massage or cold packs, is usually applied within minutes to hours after injury. When ice is applied directly to the skin, initial discomfort is experienced, followed by

local analgesia. Ice massage is usually limited to an application of short duration. The use of cold beyond a matter of minutes requires some protection of the skin. Here, cold packs applied over protective covering are effective. Application of cold in the acute condition is usually accompanied by rest and elevation of the part and frequently by pressure dressing.

One should recognize that following the application of cold which causes constriction of blood vessels and blanching, there is a rebound dilatation, increased circulation, and reddening. This may be accompanied by relief of muscle spasm and a sedative effect.

For this reason, cold is sometimes used in the relief of pain and muscle spasm sometime after the initial injury, in the form of continuous cold, or in the form of contrast baths. The decision as to the choice of cold or heat is usually an individual one and the acquisition of skill in the technique is responsible for reported effectiveness of this form of treatment.

For the treatment of injury after the initial 12 to 36 hours, the application of heat can be expected to afford relief of pain and relaxation of muscle spasm. Because of its biological effect on tissue, it is particularly suitable as a preliminary to exercise, especially where stretch of fibrous tissue is anticipated. The choice of modality will be dependent on the location of the injury, on whether heating is to be mild or vigorous, and on other factors.



Mechanotherapy is the use of mechanical methods to relieve pain, reduce swelling, promote metabolism, or to stretch soft tissue (Table 2).

TABLE 2

MECHANOTHERAPY

Massage:	Relieve pain Reduce edema Promote metabolism Manual Mechanical compression
Traction:	Stretch soft tissue Relieve root compression  Manual Mechanical

Massage is effective in reducing swelling. Edema fluid in the tissues interferes with tissue metabolism and motion of the part, and may be painful. Unrelieved edema over a period of time results in fibrosis and permanent disability. Massage may be applied manually or by means of intermittent mechanical compression.

Soft tissue may be stretched using manual or mechanical traction devices. This may be particularly useful in conditions where there is secondary nerve root compression, as in neck injuries. Traction is usually preceded by X-ray studies to rule out fractures, dislocations, or underlying disease which would serve as contraindication.

As indicated previously, the use of ther-motherapy is usually a preliminary to some form of therapeutic exercise, the purpose being to maintain or improve joint range of motion, develop improved coordination, or increase muscle strength (Table 3).

TABLE 3

THERAPEUTIC EXERCISE

Maintain or improve range of joint motion Improve coordination Strengthen muscles
Passive Active assistive Active Resistive Manual Progressive Isometric Isotonic

The type of exercise will vary with the condition and location. It may be passive, with the therapist moving the part; active, assisted with both parties participating; or active, with the patient moving the part through its range of motion. Passive and assisted exercises are provided during initial exercise for range of motion, including stretching and in early strengthening. In the latter situation, once the part

can be moved against gravity, resistance is applied. This may be manual resistance or progressive graded resistance, with (isotonic), or without (isometric), motion through the joint range.

Various techniques have been developed for resistive programs. Advocates can be found for each of these and for the choice of either isometric or isotonic exercise. In either event, the muscle will respond to stress with increase in fiber strength and muscle bulk.

As mentioned before, the choice of heat modality depends on its physical properties and the physiologic effects desired. In certain situations, particular benefits are to be derived from a particular type. Generally, it is satisfactory to use whatever is most readily available (Table 4).

TABLE 4

EFFECTS OF HEAT

Blood flow	Blood vessels Local temperature Local metabolism
Metabolites Edema Muscle spasm Nerves Fibrous tissue	
MILD	REFLEX
VIGOROUS	DIRECT

The effects of heat are to increase the temperature locally and to increase the local metabolic rate. There is dilatation of blood vessels and an increase in blood flow. The permeability of vessel membranes is increased, resulting in diffusion of the products of metabolism.

One result of this effect on blood vessels is to increase edema. For this reason, heat is generally not preferred in the acute condition.

Relief of pain is afforded by direct effect on the local nerves and with relief of muscle spasm. Application of heat has a general sedative effect. The subject may fall asleep during the application of heat. This may be desirable, but may represent a potential danger from burning if unsupervised.

A further effect of heat is on collagen, or fibrous tissue. Fibrous tissues are rendered easier to stretch by increased temperature.

The indications for heat, then, are desired analgesia, increased blood flow, sedative effects, and as a preliminary to the stretch of fibrous tissue (Table 5).



TABLE 5

**HEAT — INDICATIONS**

Analgesia  
 Increase blood flow  
 Accelerate suppurative process  
 Relieve muscle spasm  
 Precede stretch of fibrous tissue  
 Sedative

**HEAT — CONTRAINDICATIONS**

Impaired sensation  
 Impaired circulation  
 Noninflammatory edema

Some contraindications to the use of heat, absolute or relative, are impaired circulation, impaired sensation, and noninflammatory edema.

Heat modalities may provide superficial or deep heating (Table 6).

TABLE 6

**MODALITY CHOICE**

<b>Superficial</b>	0.1-3 mm
Mild	Available
Inexpensive	Safe
Whirlpool	Paraffin
Infrared	Hot packs
<b>Deep</b>	2-3 cm
Vigorous	
Penetrating	
Biologic effects	
Diathermy	

Superficial heating is mild, usually relatively inexpensive, available, and safe. Each modality may have its advantages. Whirlpool is desirable in that exact temperature control is possible, and there is some massage and sedative effect from the water motion. Exercise is possible during its administration.

Paraffin baths allow safe and inexpensive heating of the small joints of the hands and feet. The temperature can be controlled within narrow limits.

Infrared is safe, inexpensive, and generally available. Exposure is controlled by the distance from the part and the part may be observed during treatment.

Other forms of superficial heat include the heating pad, hot baths, and hot packs. The moist heat of the hot pack is effective. Packs are easily available and inexpensive. Precautions must be taken to protect the skin from burns.

These superficial heat modalities penetrate only 0.1 to 3 millimeters into the skin, are mild, and exert their effects largely in a reflex manner.

Where deep, more vigorous application is desired for heating of the deep subcutaneous, muscle, and joint tissues, various forms of diathermy are employed. These are short wave, microwave, and ultrasonic diathermy. Their effectiveness is based on heating effects during passage through tissue of high frequency alternating current, electromagnetic radiation, or high frequency sonic vibrations. The deep heating modalities allow for elevation of tissue temperatures. Each modality has its particular therapeutic indication (Table 7).

TABLE 7

**DEEP HEAT MODALITIES****Short Wave Diathermy**

High frequency electricity  
 (13.66, 27.33, 40.98 megacycles)  
 Power supply  
 Oscillating circuit  
 Patient circuit (Applicator)

**Microwave Diathermy**

Electromagnetic radiation  
 (2450 megacycles)  
 Power supply  
 Magnetron tube (oscillation)  
 Antenna (applicator)

**Ultrasonic Diathermy**

High frequency sonic vibrations  
 (0.8-1 megacycle)  
 Power supply  
 Oscillating circuit  
 Transducer (medium)

Short wave diathermy produces its effects by conversion to heat of high frequency alternating current as it passes through tissues. It produces its highest temperatures in deep subcutaneous and superficial muscle tissues. Joint heating is accomplished when the joint is covered with a relatively small amount of soft tissue. Application is by drum or cable. There is no way of controlling dosage and one must rely on the sensation of warmth experienced by the patient.

Microwave diathermy, or radar waves, produce heat by the passage of electromagnetic radiation through tissues. The effects are essentially those of heating. Its main advantage over short wave diathermy is its ease of application, similar to that of shining a light on the patient. As with short wave, the duration of treatment is 20 to 30 minutes. The area treated is left uncovered and the sensation of warmth indicates the dosage. The heat is largely concentrated in subcutaneous fat and muscle. Heating of superficial joints is accomplished. For most effective heating the joint should be heated from several directions.



Ultrasound produces its heating by conversion of high frequency sonic vibrations as they pass through tissue. It is the most effective form of heat for deep penetration, particularly for deep joints such as the hip. It causes relatively little elevation of temperature in superficial tissues and has a greater depth of penetration than short wave or microwave diathermy. It may penetrate as much as two to three centimeters. Ultrasound can be utilized in the presence of metallic implants.

Dosage and duration of treatment can be measured. Application is by means of a sound head moved over the part, using a coupling agent, for a period of three to ten minutes. Dosage is measured in watts per square centimeter of surface area. Although many non-thermal effects have been ascribed to ultrasound in industrial and similar usage, in clinical application the significant effects are due to heating.

With application of all modalities, certain general precautions are necessary. In addition, specific precautions are to be considered with individual modalities (Table 8).

TABLE 8  
PRECAUTIONS

Remove clothing  
Observe area before, during, after  
Test sensation  
Provide instruction  
Control temperature and dosage  
Metallic implants  
Impaired circulation

In all instances, clothing should be removed before treatment. The area should be inspected before and after treatment and, where feasible, during application. The presence or absence of normal sensation must be determined, particularly with modalities for which exact dosage measurement is not possible. Impaired sensation would contraindicate the use of any heating modality which depends on patient cooperation.

Impaired circulation to an area is a general contraindication to local heating. Metallic implants would preclude the use of deep heating modalities with the possible exception of ultrasound.

In all instances, the patient should be instructed as to the anticipated effects and cautioned to report sensations of pain or excessive heat. In all questionable cases, application should be discontinued.

The safe and effective use of all modalities of treatment is dependent on accurate diagnosis and localization, full knowledge of the physics and physiologic effects of the modalities and their technique of application, and the indications and contraindications, both general and specific.

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### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO

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5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
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8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

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2. Please attach a 50-100 word description of the exhibit: \_\_\_\_\_
3. Give amount of space required, depth, width, and height: \_\_\_\_\_  
  
If exhibit has side panels, are depth and width included above? \_\_\_\_\_  
  
If not, what additional space is required? \_\_\_\_\_
4. Electrical or other requirements: \_\_\_\_\_  
\_\_\_\_\_
5. Has exhibit been shown at other medical meetings? \_\_\_\_\_  
\_\_\_\_\_
6. Name and title of exhibitor: \_\_\_\_\_  
\_\_\_\_\_
7. Name of institution cooperating in the exhibit: \_\_\_\_\_  
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**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia. Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

**Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

**Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

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# C I B



# Preservation of Sight in Sports

JOSEPH W. BERKOW, MD

Filbert Foundation Laboratories

Wilmer Institute, The Johns Hopkins Hospital

With the exception of boxing, most sports injuries to the eye are accidental. In most sports, ocular damage is usually due to contusion injury to the eye. This may be from the blunt force of a ball or other piece of equipment, or from forceful contact with the body of a teammate or opponent. Therefore, the chief goal in the preservation of sight in sports is the protection of the eye from accidental trauma.

Eye injuries in athletes are relatively uncommon when compared to injuries to bone and muscle. The eye is rather well protected by orbit, and the eye itself is a fairly tough structure. Most of the eye injuries that occur in supervised sports are relatively minor and cause little if any permanent damage, although serious ocular injuries occasionally occur.<sup>1, 2</sup>

## Susceptibility to Eye Injury

One of the things necessary for the preservation of sight in sports is the recognition of certain groups of people who are more susceptible than others to ocular injury from trauma. Among them are those with a high degree of myopia, those who have had previous eye surgery (especially surgery for retinal conditions), those with monocular vision, and those with amblyopia.

Myopic persons with a large refractive error in the range of eight or more diopters of myopia — the high myopes — have a much higher incidence of retinal and vitreous degeneration than the general population.<sup>3</sup> They may develop retinal pathology and retinal detachments even while teenagers. These people should not engage in contact sports. Their risk of permanent injury and even blindness is high, even from relatively minor trauma.

Anybody who has had previous eye disease or eye injury should be carefully evaluated before being allowed to compete in a contact sport. Anyone who has had the lens of the eye removed

because of a congenital or traumatic cataract, or who has had retinal detachment surgery, runs a great risk of serious injury to the eye from contusion.

A third group of people who should refrain from engaging in contact sports is those who are actually or functionally one-eyed. Someone who has lost one eye for any reason should not risk injury to the remaining eye. Another — probably larger — group of persons who are functionally one-eyed are those with an amblyopic or “lazy” eye. These people have two anatomically-good eyes. For various reasons (such as unilateral refractive error, strabismus, etc), one eye has poor visual acuity.

It is probably inevitable that injuries will occur on the playing field. Our goal, then, is to keep them to a minimum. It is with this goal in mind that various safety devices have been designed. Modern technology has provided many lightweight, strong and resilient materials with which to fabricate them.

## Protective Equipment

If our desire to protect the athlete from accidental injury is to be effective, more is necessary than providing him with good equipment: **he must use it.** Today, fairly good items of equipment are available for protection against eye injury from balls and other blunt forces if the athlete will use them. This includes such devices as squash glasses and safety glasses. Football helmets and other types of head pro-



tectors also provide a certain amount of protection to the eyes, although they may obstruct the player's view.<sup>4</sup> These devices are now usually made of high-impact plastic, and are designed so that they do not restrict the athlete's view or impair vision to an objectionable degree. For this reason, most athletes are quite willing to use them.

The athlete who does not require glasses still requires eye protection if he is playing hockey or squash or other such sports in which a high-speed missile is involved. Squash glasses are available and will provide protection. This device is made of tubular metal, is lightweight, and is padded so that any applied force is transmitted to the bone of the forehead and cheek. It therefore converts a potential eye injury to a minor facial bruise. It also has the necessary advantage of not restricting vision.

Not all athletes are endowed with good, uncorrected vision. For those who require an optical correction, safety glasses and contact lenses are available.

Safety lenses are available in two basic types: tempered glass and plastic. The glass lenses are at least 2 mm thick in their thinnest portion, and are therefore heavier than ordinary spectacle lenses. They have the important property of not splintering when broken. They are also much stronger than the crown glass usually present in ordinary spectacles and resist force that will break an ordinary lens.

The plastic lenses have been much improved in recent years. Even the early plastics used for spectacle lenses were very resistant to breakage, but they did have the disadvantage of scratching easily and of yellowing with age. The new allyl plastics have overcome both of these disadvantages to a very large extent and are to be recommended.<sup>5</sup>

The safety frame is an eyeglass frame made out of nylon, with an elastic strap that goes around the back of the head. The frame is very strong, flexible, virtually unbreakable, and is designed to hold a tempered glass or plastic lens. The hinge is made so it can open 180 degrees rather than break apart.

For the athlete who needs an optical correction to obtain his best vision but who does not want to wear glasses, contact lenses are available. Contact lenses have been increasing in popularity. Their safety has been demonstrated many times. They also have other advantages

that contribute to their popularity. Contact lenses do not become dirty or fog up during play as glasses do; yet, in addition to refractive correction, they provide a full visual field and protection for the eye.

Of the two general types of contact lens in use today, the smaller corneal type is by far the most popular. The larger scleral lens is not as comfortable and has a shorter wearing time. In contrast, the smaller corneal lenses are usually very well tolerated, provide good vision, and can be worn for relatively long periods of time by most people. In a recent article on vision in sports, it was stated that 16 out of 80 players on the Cornell football team wore contact lenses while playing. All but one of these wore the small corneal lenses.<sup>6</sup>

However, contact lenses do have a few disadvantages. If a small foreign body gets into a player's eye, the lens must be removed immediately. If the foreign body gets between the contact lens and the cornea, it will cause severe pain and may damage the cornea. Occasionally the contact lens is knocked out of the eye. Therefore, a spare lens should be available.

### Ocular Injuries

In addition to proper equipment, the next basic step in the preservation of vision in sports is the recognition of injuries when they occur.<sup>7</sup>

This statement may seem rather obvious, but we must consider the fact that the eye is a very small organ and that most of it is hidden. A swollen bruised lid, which is itself a rather mild injury, may hide a serious ocular injury.

The injuries that we see are mainly those produced by contact with elbows, knees, hands, balls, hockey pucks, lacrosse rackets, and the like. In this regard, we can divide the sports into various types. There are those that are primarily or entirely contact sports, such as football and wrestling, and those that are played with the smaller missiles — balls and pucks. One rarely sees an eye injury from contact with a relatively large slow-moving ball, such as a basketball or volleyball. A small, relatively high-velocity ball — such as a squash ball, handball, lacrosse, or tennis ball — causes injury more often. As the ball considered gets smaller, the incidence of injuries to the eye increases. As the velocity of the ball increases, so does the extent of the injury. A very high-speed small ball, such as a golf ball, can rupture the eye. Fortunately, because



of the nature of the game, this type of injury is rare.

Contusions and abrasions of the eyelids are perhaps the commonest eye injuries that occur in sports. The black-and-blue eyelid looks serious, but in itself it is a very minor injury. It usually heals readily without sequelae. Lacerations of the lid are more serious, but they are usually readily apparent, and therefore treatment is sought promptly.

Ocular injuries can involve bleeding in and around the eye. The subconjunctival hemorrhage is the most striking in appearance and is probably the most common. If this is the total extent of the injury, it is innocuous. Although it will look bad for a while, it will heal without sequelae. In this instance, the blood is in or under the conjunctiva. However, if the blood is inside the eyeball, a much less apparent but much more serious injury has occurred — one that can lead to severe loss of vision. Blood in the anterior chamber of the eye (hyphema) usually clears, but it has the potential for very serious sequelae, such as glaucoma, recurrent bleeding, and possible loss of the eye. Patients with anterior chamber hemorrhage should be hospitalized. Blood in the vitreous of the eye almost always causes a decrease in visual acuity, and it may be the first sign of serious injury to the retina.

Abrasions of the cornea are fairly frequent among eye injuries. They are painful, and therefore medical attention is promptly sought. Usually, healing occurs in a few days with proper treatment.

More serious injuries, such as tearing of the iris, dislocation of the lens, or retinal damage may occur with very severe contusion and lead to marked loss of vision, so that ophthalmologic consultation will be obtained.

Sometimes a blunt force to the eye will be transmitted to the tissues surrounding the eye, without injury to the eyeball itself. The bone that forms the floor of the eye socket (the orbit) is very thin and is thus a weak spot in the orbit. The orbital floor or wall may fracture, and if one of the muscles that are attached to the eye is trapped in the fracture, diplopia or double vision may result. This is a very distressing and disabling symptom. The treatment of such an orbital fracture requires surgical reduction of the fracture with freeing of the trapped muscles, although less severe fractures may not require surgery.

## Summary

The preservation of sight in sports is a task that may be divided into four large categories.

1. The recognition of a group of people who, because of preexisting ocular disease or injury, are more susceptible to ocular injury from contusion trauma than is the general population. These high-risk people must be evaluated regarding possible permanent loss of vision from injuries they might sustain in sports.

2. The provision of adequate safety devices, such as goggles and helmets, in sports such as squash and handball in which a small, high-velocity ball can cause serious ocular injury if it hits the eye, and the use of safety equipment in sports generally.

3. The use of safety glasses or contact lenses by athletes who require optical correction of a refractive error.

4. The recognition of ocular injury when it occurs, so that prompt and suitable treatment can be obtained.

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*Presented in cooperation with the Maryland Society for the Prevention of Blindness, 1313 W. Old Cold Spring Lane, Baltimore, Maryland 21209, Telephone 243-2201. Contact them for reprints.*



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*"Restoration worthy of that word will only come if the minds of all engaged in the sacred work are always fixed on this central truth: "Body and spirit are inextricably conjoined; to heal the one without the other is impossible."*

*John Galsworthy*

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FREDERICK J. BALSAM, MD, EDITOR

## **rehabilitation medicine**

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# Vocational Evaluation and the Stroke Patient: A Discovery of Self

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Vocational Evaluation affords the stroke patient an opportunity to actively explore many areas of vocational potential. In this way the individual can determine his own abilities, liabilities, and realistically participate in planning his future. This is also true for individuals with other disabilities whether psychiatric, social, physical, or intellectual.

There are, of course, some dangers inherent in this type of program because the individual discovers what he cannot do. This can inhibit his utilization of the defense of denial, causing depression and anxiety. Properly planned and executed, the results of a Vocational Evaluation have excellent predictive value.<sup>1</sup> The program as implemented in Sinai Hospital's Department of Rehabilitation Medicine is three-phased.

### **First Stage**

The first stage is the most theoretical. The emphasis is on group psychological testing. This includes interests, aptitude, intelligence, reading, and dexterity tests. Maximum usage is made of non-verbal testing. An example is the Culture Fair Intelligence Test.<sup>2</sup> This was formerly known as the Culture Free Intelligence Test. Both of these names are inaccurate in that any

test that uses a paper and pencil has some cultural bias. Therefore, a more appropriate name would be the Culturally More Fair than Verbal or Numerical Intelligence Test.

### **Second Stage**

The second stage of the Vocational Evaluation process involves the use of worksamples. A worksample is a phase of work as actually performed in an office, factory, or other facility. The setting is different, but the work itself and abilities required in its performance are the same.

Samples range from the simple to the highly complex and represent many occupations. These include carpentry, machine shop, drafting, and cashier activities. The main body of worksamples are published by the Institute for the Crippled and Disabled known as the TOWER System.<sup>3</sup> Additionally, some worksamples have been developed at Sinai Hospital while others were developed at the Baltimore League for Crippled Children and Adults. A great assortment of handtools is available in the Vocational Evaluation center. Saws, wrenches, rulers, files, sanders, planes, and jewelry saws are some of the hand equipment available.

An industrial sewing machine is available as a



means of measuring ability for its use and as an instrument in evaluating a person's potential in the use of high speed industrial equipment. A cosmetology worksample was developed with the cooperation of a beauty culture school in Baltimore city which donated a mannequin with an attached wig.

For individuals who wish to explore areas requiring fine dexterity, there are electronics assembly and jewelry manufacture. Often, clients have a stereotyped view of the requirements of these occupations. Electronics, for example, is advertised by the mass media and even comic books as being an easy way to earn money and gain prestige and respect. Obviously, these rewards are desired by workers in almost any area. When a young person states that he wants to go into electronics, he might actually be saying that he would like to earn a significant income and receive the respect of his fellow workers and family. It is therefore essential to have an active vocational evaluation process in which stereotype views of occupations can be broken.

There are many clerical areas available. One of our stroke clients, a right hemiplegic, was given a one-handed typing worksample. In addition, he was given an opportunity to evaluate his ability to follow detailed written instructions by sorting envelopes with multiple symbols on them. Through this process, it was ascertained that he could follow written instructions and do clerical work. Since he had retained his intellectual capacities, he could, and did, re-enter the legal profession.

### Third Stage

The third stage of Vocational Evaluation utilizes many of the hospital work areas. A community hospital is like a city in that it contains its own laundry, storeroom, print shop, engineering and maintenance, and housekeeping departments, to name a few. In this way, the client has the opportunity not only to exhibit skills, but to perform in actual work situations. Area supervisors are able to evaluate a client's actual work capability and his ability to relate to other workers. This has the tendency to keep the Vocational Evaluation Program oriented to reality. This does not eliminate the recognition that a client can improve, and that the problems which inhibit his productivity at the present time may be mitigated with the aid of the other therapies available in the rehabilitation center and the hospital.

One of our stroke patients was placed in the engineering and maintenance department working with sheet metal. He had been a sheet

metal worker but was unable to continue the production part of this occupation because of his loss of mobility. As a result of his successful performance, he was hired by the hospital as a part time worker in engineering and maintenance. The Vocational Evaluation process gave him the opportunity to demonstrate his abilities to his new employer and himself.

Another young man, who has residuals of loss of memory and balance due to head trauma, was given the opportunity to explore his potential in the print shop. He was trained as a printer's helper and is now working in the community. During this training program, he was instructed in many skills useful in the printing industry and also in the use of audiovisual equipment.

Another young man, who is brain damaged to the extent that he cannot write his name or center it when he is copying from his employee's card, was given the opportunity of vocational exploration in the laundry. He had been rejected by a sheltered workshop for a ten-cent-an-hour position because of his limited ability. Because the workshop did not have anything but small assembly tasks, this rejection was appropriate. He is now working in a laundry earning over \$2.50 per hour. His lack of coordination and intellectual limitations do not hamper his ability to stuff clothing in a large washing machine and then pull it out when the cycle is completed.

Many people have had the opportunity to explore working with children in the pediatric department. This is done after careful screening, so that traumatic situations can be avoided. Interestingly, one of the individuals who exhibited the most skill working with children decided that she did not like this type of work. This is another indication that the active Vocational Evaluation process allows individuals to establish realistic vocational goals consistent with their abilities and interests.

Similarly, an individual with minimal brain damage was given the opportunity to become a productive worker in the hospital kitchen and is presently employed in private industry as a meat cutter.

Because many stroke patients do not have the residual ability to return to competitive employment, the program has started its own work activity center. In this environment, each individual is paid for what he produces. There is no pressure for production beyond individual capabilities. For the stroke patient, recreation is not always a beneficial outlet. A mature worker who has spent his adult life identifying with work may find more reward producing within



his limitations in a sheltered workshop than at recreational activities. This is because many of these patients have spent the major part of their lives being conditioned to the prestige of work. Although the major emphasis is for terminal employment, one patient with jargon aphasia has improved so much in the workshop that competitive placement is being considered for him. This workshop is small, holding a maximum of ten clients. The need for sheltered employment outlets for stroke patients is significant beyond such limited capabilities. Expansion in this area is urgently needed.

### Theoretical Construction

Although never applied to handicapped workers before, Maslow's Need Theory and Buehler's Life Stage Theory offer significant contributions in explaining many of the emotional problems presented by clients during Vocational Evaluation.

#### Maslow's Need Theory<sup>4</sup>

1. Physiological
2. Safety
3. Belongingness
4. Importance, Respect, Self-esteem, and Independence
5. Information
6. Understanding
7. Beauty
8. Self-actualization

#### BUEHLER'S LIFE STAGE THEORY<sup>5</sup>

1. Growth - conception to 14 years
2. Exploratory - 15 to 25 years
3. Establishment - 25 to 45 years
4. Maintenance - 45 to 65 years
5. Decline - 65 and above

Using Maslow's Need Theory, we see that it is a hierarchical structure ranging from the most basic needs to the more abstract ones. Of course, when the patient has a stroke, his most important needs initially are in the areas of safety and stability of function. Difficulties arise when the patient has residual limitations that cause him to re-evaluate himself and his role. This may lead to the overwhelming defense of denial. Many individuals cannot allow themselves to believe that they have changed. We can see that it would be difficult for an aggressive male who has been the breadwinner of a family to see himself as being important or deserving of respect and self-esteem if he no longer can fulfill his breadwinning function. Also, this may affect his ability to perceive himself as an object capable of belonging in the family and being

loved. Of course, perceptual or speech difficulties could inhibit the fulfilling of the patient's need for information and understanding. It is now seen that major emotional difficulties may arise from the residuals of a stroke that have nothing to do with the patient's actual physical condition.

As far as Buehler's Life Stage Theory is concerned, the exploratory stage — 15 to 25 years — is stereotyped in our society as being the carefree years without responsibility. Actually, this stage is one of the most difficult to complete successfully. The youthful individual has little experience in choosing or understanding the major changes affecting him and the responsibilities that he knows lie ahead. The major asset that an individual has during these years is youth and its energy.

The individual who has reached his maintenance years will be in a most difficult position if a stroke inhibits his ability to continue to gain benefit from his previous years of achievement. During this maintenance stage, the individual has more or less reached a plateau and is consistently producing but not adding to his production. If this individual has a stroke and has to go back to the exploratory stage, he will meet all of the previously explained difficulties that one encounters during this stage without having the advantage of youth. The individual will have to go through a stage that is probably the most demanding in energy and in the ability to tolerate anxiety. He will have to do this with a confused self-concept, feelings of inadequacy, and limited physical ability. It is not difficult to envision the emotional difficulties that may surface. In addition to this, he may have to deal with difficulties and fear of further stroke and death.

For these reasons, a Vocational Evaluation process that allows the client to explore many areas in a short time can be most beneficial. Also, it may help the client to establish a new, yet worthwhile self-concept as a productive human being.

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**PRESCRIBING INFORMATION** **Indications:** Primarily for treatment of infections due to susceptible strains of *Pseudomonas aeruginosa*, *Proteus* species (particularly indole-positive strains), and certain *Escherichia coli*. Clinical effectiveness has been demonstrated in the following infections when due to these organisms: Urinary tract infections; severe systemic infections and septicemia; acute and chronic respiratory infections (while clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis); soft tissue infections. Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: **Gram-Negative Organisms**—*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morgani*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. **Gram-Positive Organisms**—*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** **Hypersensitivity Reactions**—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. **Gastrointestinal Disturbances**—Nausea. **Hemic and Lymphatic Systems**—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. **Hepatic and Renal Studies**—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. **Central Nervous System**—Convulsions or neuromuscular irritability could occur with excessively high serum levels. **Local Reactions**—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials. Before prescribing or administering, see package circular or PDR.

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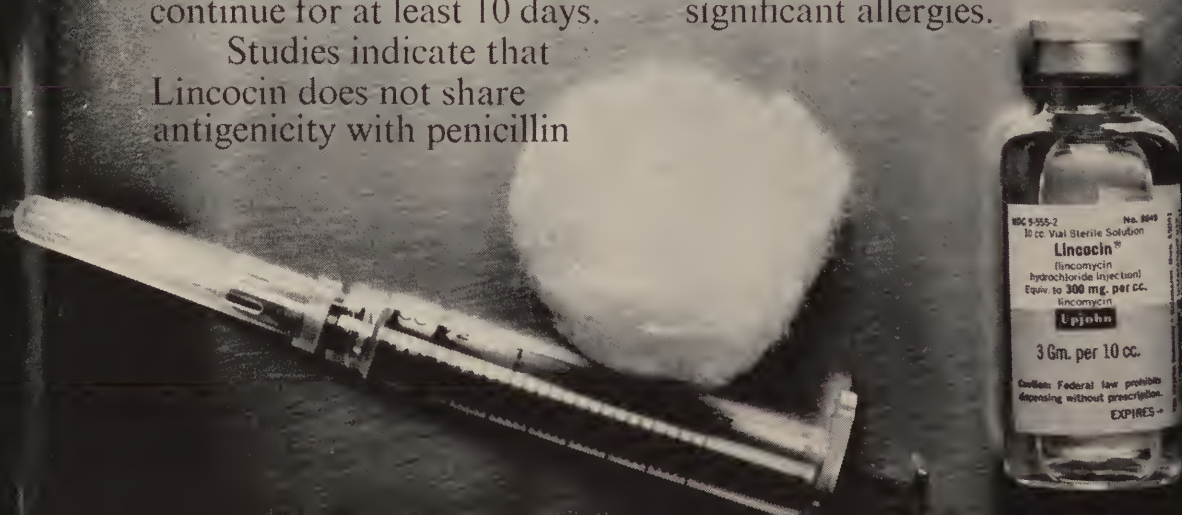


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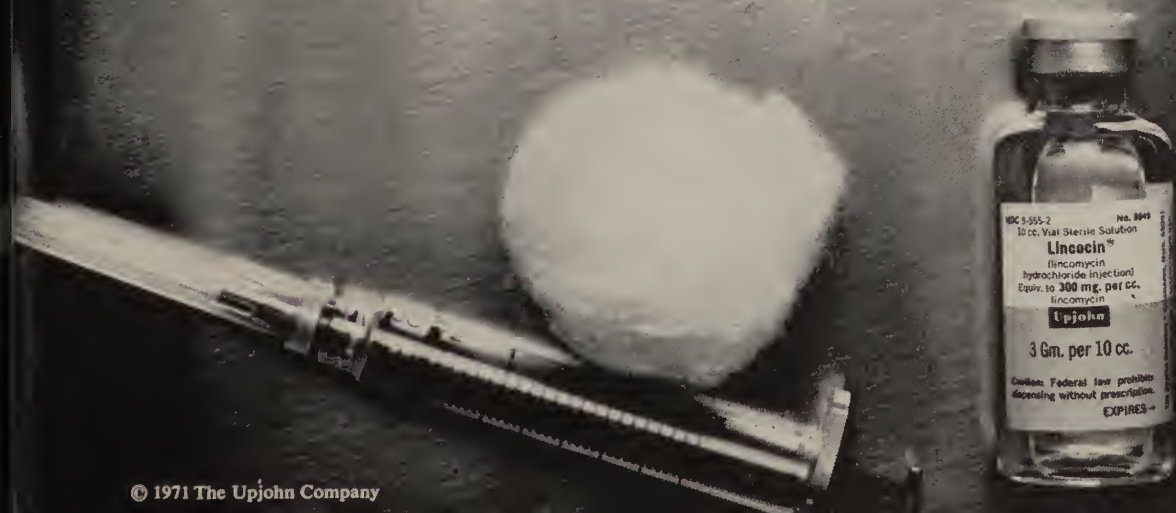
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**CONTRAINDICATIONS:** History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or

significant allergies. Overgrowth of non-susceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angio-neurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.

**Cardiovascular**—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. **Local reactions**—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced local irritation or phlebitis.

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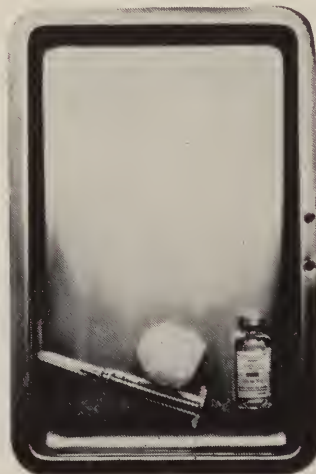
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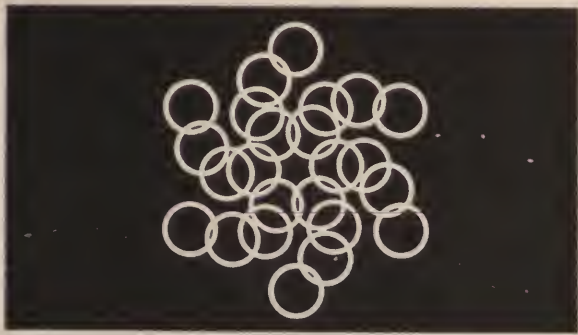
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From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# The Drunken Driver in the Alcoholic Rehabilitation Program

**RICHARD W. ESTERLY**  
Parole and Probation Agent  
Prince George's County Division  
of Parole and Probation

In recent years, there has been a rapidly growing concern over the large number of fatalities on the highways due to drunken drivers. National authorities estimate that over 50% of the yearly 50,000 traffic deaths and 800,000 non-fatal accidents are caused by drunken drivers. A recent study in Maryland revealed that two thirds of the fatal accidents in the study were related to drunken drivers. This means at least 400 deaths nationally a week.

Many areas of the country are instituting special programs in order to combat this tremendous problem. These efforts include a program in Ann Arbor, Michigan which gives the offender the choice of a daily anti-alcohol pill (antabuse) or a 30-day jail sentence. If the offender drinks after taking the pill, the individual becomes unpleasantly ill. Other areas are using free breathalyzers distributed at liquor stores, increased police patrols equipped with T.V. video tapes, and educational programs.

Prince George's County, under the guidance of Berger M. Bankston, initiated a program to combat the ravages of alcoholism more than ten years ago. This program has the advantage over other programs for it aims at the basic underlying alcoholism problem instead of the symptomatic behavior of drunken driving. A California study has shown that two thirds of the offenders with revoked driving permits continue driving.

An ongoing evaluation of this Alcoholic Rehabilitation Program conducted by the Department of Parole and Probation has constantly shown a 34% success rate during probation. It is of interest to note that the investigation made reveals that offenders charged with driving under the influence have an as-

tounding 84% success rate. All other traffic charges have a 54% success rate, which is also much higher than the 34% average of the group.\* What is even more surprising is that the Prince George's Police Department reports that there were 308 persons charged in 1969 with driving under the influence. In that same year the chart reveals that there were only ten attending the Alcoholic Rehabilitation Program. They report that there were 351 persons charged in 1970. In 1970 there were only six attending the program. However, it is significant to note that the court has increasingly made use this year of the Alcoholic Rehabilitation Program. Currently, there are approximately 60 D.W.I. offenders attending the program.

In conclusion, the Alcoholic Rehabilitation Program has shown a very high success rate with persons charged with driving under the influence. This high rate is attributed to the following reasons:

- 1) The persons are more likely to be in the earlier stages of the disease of alcoholism and, therefore, more socially integrated (eg, family, job.) This makes them more amenable to treatment.
- 2) They are more likely to view themselves as having a problem and having committed a crime than a person involved in a domestic quarrel.

\* 44% of those charged with D.W.I. were utilized as group leaders during their period of probation which is one of the surest signs of success. Only 2% of the persons charged with D.W.I. had their probation revoked while 17% of those charged with other traffic charges had been revoked.



- 3) They also have something of great value to lose in that their driving privileges are at stake. They are much more likely to have their permits reinstated if they do what is necessary in order to cope with their drinking problem.

Due to these reasons, the person charged with driving while under the influence appears to be benefitting materially by attending the Alcoholic Rehabilitation Program. This program and all services of the Department of Parole and Probation are designed to meet the needs of the courts. We will continue to expand and improve these programs as the courts continue to utilize them.

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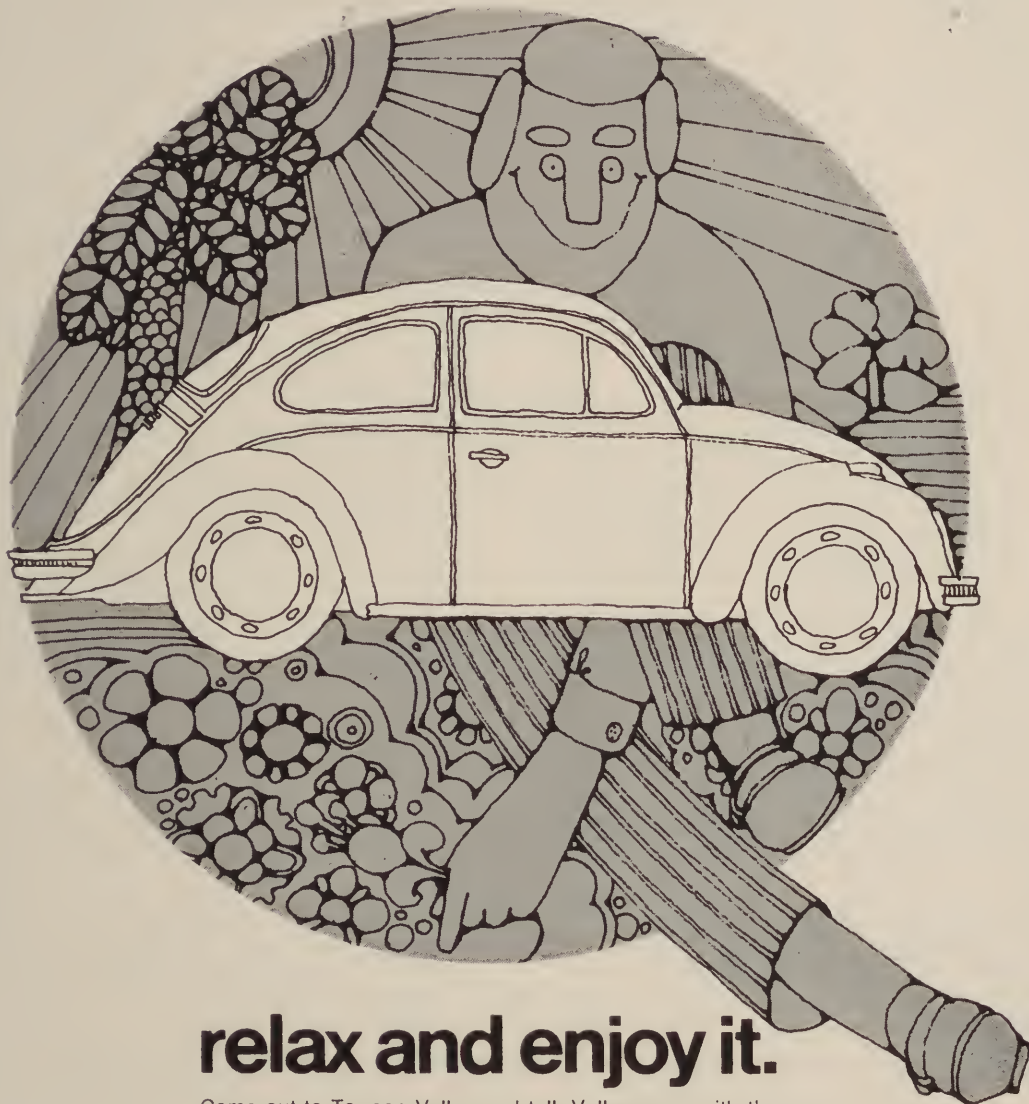
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**Contraindications:** Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine.

Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon®).

**Warnings:** **USE IN PREGNANCY:** Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

**USE IN CHILDREN:** The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

**Precautions:** It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

**Adverse Reactions:** Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established. **Dosage and Administration:** Adults—1 to 2 tablets 3 to 4 times daily.

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# REPORT OF PEER REVIEW COMMITTEE TO HOUSE OF DELEGATES-7/21/71

*Mr. President and Members of the House of Delegates:*

Foundations for Health Care have been on the scene since the early 1960s. In 1962, a report was presented to the Council of the Medical and Chirurgical Faculty dealing with their organization, responsibilities, and duties. This report read as follows:

## REPORT ON FOUNDATIONS FOR MEDICAL CARE

### Introduction

Considerable debate has arisen over setting of fees by a third party to be paid physicians who render various types of medical care. In some instances physicians have had to accept the set fee, regardless of what might be a fair fee for services.

Another area of controversy is that of Blue Shield fee schedules which were established many years ago. In order for these to be changed, approval has to be obtained through the Insurance Commissioner. In some states, the Insurance Commissioner has refused to approve any changes in schedules that were made by the medical societies. In effect, the Insurance Commissioner in Maryland has the power to establish fee schedules for medical service which physicians must accept as payment in full if they are participating in the Blue Shield programs.

The physician is the only one who has accepted the so-called service concept of accepting a set fee as payment in full or of pro-rating his fee downward for patients in low income groups. By the same token, the physician is the only one who has permitted third parties to establish fees without consultation with an official body of organized medicine. Furthermore, the medical profession has been more progressive in its thinking toward the provision of newer and additional benefits to the public — not only to provide better services to the patient, but to include areas previously considered “uninsurable” and “preventive.”

Over the years, the public has demanded more and more prepayment systems for health care. The public has become accustomed to budgeting for all of its needs, including medical needs. The public, at large, as well as labor unions, has requested first and final dollar coverage for its

health care. The cost of providing such care has become a secondary consideration to the wish for it.

The medical profession must either provide an equitable solution to this problem or allow government or organized labor to intervene. The Foundation for Medical Care concept is one answer to this problem.

### Concepts

The Foundation for Medical Care concept originated in California in the late 1950s. Threatened by a closed panel type of program being considered by a local labor union, the San Joaquin County Medical Society organized the San Joaquin Valley Foundation for Medical Care. Controlled and operated by the medical society, the nonprofit Foundation provides the highest quality medical care while, at the same time, preserving free choice of physician and of insurance carrier.

The specific and primary objectives of a Foundation for Medical Care are:

- 1) To promote, develop, and encourage the distribution of medical services by its members to the people of the area served, at a cost which is reasonable to both patient and physician.
- 2) To preserve unto its members, the medical profession at large, and the public, freedom of choice of both physician and patient.
- 3) To guard and preserve the physician-patient relationship and its innumerable benefits.
- 4) To protect the public health.
- 5) To work and study in cooperation with the insurance industry and those service plans which provide for periodic and realistic budgeting for medical care and for free choice of physician and which guarantees preservation of the physician-patient relationship.

Benefits summarized then, are:

### To the Patient or Insuree

1. Certain minimum benefits.
2. Predictable costs. Even for items not covered in the contract, physicians agree to charge no more than the fee schedule specifies.
3. Quality control by physicians.



## To the Physician

1. Adequate fees — controlled and established by the medical profession itself.
2. Free choice of physician and patient.
3. Free choice of insurance carrier.
4. Certainty of coverage with service benefits based on income of group insured.
5. Improvement in standards of health insurance in the area covered.
6. Clear statements on drafts paid to physician, with copy to patient, stating what is covered and what is not covered — in cases where balance due, amount is clearly stated and patient advised this is due physician.
7. Quality control by physicians — educational program directed to physician to prevent abuse of insurance programs.
8. Payments made only to physicians. Where services, such as X-ray or laboratory, etc., are performed by a hospital, payment is made only on presentation of bill in a physician's name.

## Benefits

Through medical society control, the Foundation can establish standards for benefits and a fair ceiling on fees, which are accepted by the physician as payment in full for service benefits to subscribers regardless of insurance carrier. The patient gains by receiving PAID IN FULL BENEFITS without additional charges being made by the physician.

The Foundation, through its members, establishes a fee schedule for the various procedures. This schedule is adjusted downward to compensate for low-income limits. Income levels then become an administrative mechanism, implementing the customary practice of lowering fees for people in need.

Income levels are based on the insured GROUP'S average income. This obviates the necessity for the physician's office nurse to ask the patient's income. Specific provisos are written into the contract to eliminate a husband and wife who are both working from qualifying under the full-payment benefit for lower income groups.

## Economics

The Foundation is not an insuring agency. It acts only in the following manner:

1. Establishes a minimum benefit program, to which it agrees that fees paid will constitute payment in full for services rendered by a Foundation member.
2. Receives, processes, reviews, and pays claims to physicians (optional).

3. Sets a ceiling on fees based on the actual charges prevalent in the area subject to adjustment in cases where "out of the ordinary" procedures or care is rendered.
4. Approves participating physicians on a yearly basis. Physicians wishing to participate must apply and pay a yearly membership assessment (\$10).
5. Reviews claims and conducts educational program in connection with rendering of care. It is not a policing agency, but acts only to discuss with those physicians the type of care being rendered. It can refuse to renew the Foundation membership of a physician if this is in the best interest of the Foundation and the public.
6. Acts as a catalyst to bring together the insurance carrier and the group being insured. It does not collect premiums, fund monies or assume liabilities for payments under contracts it sponsors. It is not a local Blue Shield plan.
7. It advises and consults with various groups on the coverage best suited to their needs—(ie, \$50 deductible, co-insurance, major medical).

## Summary

The Medical Care Foundation, then, is a mechanism through which the tenets of the medical profession can be put to the test. By electing the members of the Foundation, the medical society itself establishes the policies and objectives of the Foundation. By offering service benefits to the public, it enables the free enterprise system to operate at its fullest. Blue Shield and commercial carriers may compete on the same basis.

By establishing minimum standards for health insurance policies under which service benefits are offered to the public, it automatically removes itself from government domination or third-party actions in setting medical fees. The insurance carrier negotiates the policy with the insuree, and the governmental obligation is only to ensure that the premium is actuarially sound.

Control for self-discipline, when necessary, is invested in the medical profession itself. Claims review procedures provide educational methods through which the medical profession can be made aware of its obligations to the public. Less than 2% of the physicians' claims end up in the Review Committees' meetings, but these few can cause untold difficulty and denigrate the medical profession as a whole.

Since that time, many foundations have become



involved with peer review by their monitoring capabilities of physicians' practices. Being a paying agent for all facets of medical care services they had readily available to them, through computer technology, a complete patient profile. Through this mechanism it has been able to ascertain not only the physicians' practices, but the patients as well.

As third-party payments and involvement in medical care have increased, more and more emphasis is being placed on the quality of care being rendered and paid for by such third parties. Because patients have more ready access to medical services and have little or no financial responsibility for payment for the care they seek, carriers have begun to ask questions as to the necessity for some procedures, as well as the charges for them and, indeed, whether or not such procedures were performed and were of the highest standards for the community.

With such questions being asked, there have sprung into being peer review committees throughout the country. Such committees have been looking at practices of physicians and been acting on the basis of data provided them by third-party carriers. In Maryland, this has been somewhat revealing.

While such activities can continue on the basis of such information, it is felt that demands for overall evaluation of all medical services ordered by physicians will, of necessity, be required. Only the physician can write prescriptions, can order laboratory services, can admit a patient to a hospital, and can determine to a great extent the length of the patient's treatment.

It follows, therefore, that only a physician (his peers) can provide proper evaluation in all of these areas.

While Foundations for Health Care throughout the country vary in the services they perform, it is not anticipated that the proposed Maryland Foundation for Health Care would become involved in the claims paying process. It is, however, suggested, that the Foundation for Health Care have as its prime objectives the following:

#### PEER REVIEW FUNCTION CAN BE GROUPED INTO THESE FUNCTIONS

1. **Supervisory Function** is the watchdog to prevent overpayment and overutilization for the primary purpose of saving money and identifying abuses.

Supervisory function, because of tremendous

outside pressure, publicity and demands, has received too much emphasis and consumed far too much time of over-burdened physicians. This is not to say that current and ongoing review is not of value — it is and it must continue — however, it needs to be streamlined.

This type of control is necessary and an appropriate task for carriers and intermediaries — but it must be done with professional direction.

There must be acceptable guidelines.

Medical advisers and physician review committees should set standards, should evaluate carrier performance, direct carriers in what they do, and adjudicate problem cases.

Another necessary part of this function is the identification and prosecution of those guilty of services abuse or fraud. While the number here is quite small, their very existence disproportionately degrades our physicians.

2. **The Scientific and Academic Function** is that of trying to improve quality care through education and the establishment of criteria for good medical management.

Today the tremendous accumulation of data on tapes of carriers and intermediaries, as well as data accumulated by hospital utilization review data systems, offers unparalleled opportunity for the evaluation of patient care.

It is generally conceded that the medical profession is best qualified to measure the quality of patient care.

The public demands assurance that quality is being evaluated and controlled.

The opportunity for the profession to fulfill this obligation to itself and to the public is right at hand. The Foundation should consider this an essential goal for the immediate future that the medical profession, in concert with other health disciplines, carriers, and intermediaries redesign effectiveness of patient care, not just the payment of claims. It is just possible that within the next few years the decision between total governmental control on one hand, and continuing reliance on the private sector will be determined by our efforts and success in developing a mechanism for measuring and controlling the quality and cost effectiveness of medicine and institutional care.



3. **The Broad Evaluation Function** is the research aspect to identify those systems, procedures, and situations capable of providing better care, more efficient delivery of health care services, and lowering costs.

We must escape the possibility of tunnel vision and open our minds to the broad implications of the different systems of medical/institutional care available to us.

**Example:**

As we evaluate the length of stay of patients in hospitals, we must consider the extent to which available alternatives influence the need for hospitalization. We have not already documented the nature and extent of the factors or extent of available alternatives.

The Foundation's proposal and program initiates a mechanism to be able to develop programs in these three major functional areas so that we can ask ourselves questions and get answers from the peer review mechanism.

In order to proceed expeditiously with the formation of a Maryland Foundation for Health Care, the following actions are proposed:

1. The Council or House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland approve the foundation of such a Maryland Foundation for Health Care.
2. That its organizational structure be developed, in concert with other providers of health services, with an invitation being extended to other organized medical groups to join with the medical profession in this endeavor.
3. That appointment of the Board of Directors of the Maryland Foundation for Health Care be directly vested with the Council of the Medical and Chirurgical Faculty. In this manner, the Foundation would be a functioning body of the Faculty, just as various committees of the Faculty presently are.
4. That the Council or House of Delegates approve the draft Bylaws, either as they are submitted or changed by either of these bodies, or approve them in principle, leaving final approval to the Board of Directors of the Foundation.
5. The voting members of the Foundation be the members of the House of Delegates of the Medical and Chirurgical Faculty; with the Council being authorized to act (as it cur-

rently is authorized to do) between sessions of the House of Delegates. In addition, the Faculty's Executive Committee be designated as officers of the Foundation with the authority to make decisions of immediate importance (as is currently their responsibility for Faculty affairs).

6. The Executive Director of the Faculty be the Chief Executive Officer of the Foundation.
7. Other deliverers of health care be invited to join the Foundation, with representation on the Board to be determined, after discussions with such groups.
8. That the purposes of the Foundation be adequately and clearly spelled out, with authority being given to the Council or Executive Committee to approve of changes in bylaws, etc., as needed or required.
9. That sufficient funds for expenses involved in the development of the Foundation structure be advanced to the Foundation, with the understanding that as the Foundation becomes operational, charges be made to third parties for its activities; and that such funds would be repaid to the Faculty.
10. That the Faculty's Peer Review Committee play an active and vital role in the Foundation operation.

Respectfully submitted,  
Arthur E. Cocco, MD, Chairman  
Richard C. Arbogast, MD  
Katherine H. Borkovich, MD  
Earl C. Clay, Jr., MD  
John R. Davis, MD  
Malcolm Peterson, MD  
Leeds E. Katzen, MD  
Watson P. Kime, MD  
Harry F. Klinefelter, MD  
Charles H. Ligon, MD  
John G. Wiswell, MD

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# MINUTES

Semiannual Session, House of Delegates

(273rd Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Saturday, September 11, 1971

Faculty Building, 1211 Cathedral Street, Baltimore, Md. 21201

The 273rd meeting of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 2:00 P.M., Saturday, September 11, 1971, at the Faculty Building, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

## Doctors:

Robert T. Adkins, Wicomico County  
Manning W. Alden, Council

\*Faye W. Allen, Anne Arundel County  
Charles Bagley, III, Wicomico County  
Timothy D. Baker, Baltimore City  
John G. Ball, Council

Robert A. Barnett, Montgomery Co.

\*Katherine H. Borkovich, Baltimore City  
Samuel Borssuck, Anne Arundel County  
M. McKendree Boyer, Past President

James B. Brooks, Council  
Douglas Gordon Carroll, Baltimore City  
John T. Chissell, Council

Arthur E. Cocco, Baltimore City  
Archie Robert Cohen, Washington Co.  
Edward F. Cotter, Baltimore City

Kenneth Cruze, Montgomery County  
William B. Culwell, Carroll County

\*Raymond M. Cunningham, Baltimore City  
Richard Y. Dalrymple, Council  
Worth B. Daniels, Jr., Baltimore City  
John B. De Hoff, Baltimore City  
De Witt E. De Lawter, Pres. Elect  
John M. Dennis, Council

\*Marshall A. Diamond, Montgomery Co.

\*Frederick Y. Donn, Montgomery County

\*John F. Eyring, Baltimore City  
Robert W. Farr, Kent County  
Vincent J. Fiocco, Jr., Carroll County  
Elliott R. Fishel, Baltimore City  
Russell S. Fisher, Past President  
Gina M. Glick, Allegany County  
Robert B. Goldstein, Council  
Edward G. Grau, Baltimore County

George H. Greenstein, Baltimore City  
John Collins Harvey, Council  
Thomas Franklyn Herbert, Howard County  
Philip W. Heuman, Council  
Charles Earl Hill, Anne Arundel County

J. Parran Jarboe, Council  
William H. Kammer, Jr., Baltimore City  
Seruch T. Kimble, Council

Louis J. Kolodner, Vice-President  
Henry P. Laughlin, Council

J. Richard Lilly, Prince George's Co.  
Elmer G. Linhardt, Board Medical Exam.  
Francis C. Mayle, Jr., Montgomery Co.  
Karl F. Mech, Council

Benjamin H. Minchew, Howard County  
Donald W. Mintzer, Baltimore City  
Marvin I. Mones, Montgomery County

\*Paul A. Mullan, Baltimore City  
William A. Pillsbury, Secretary

\*William W. Pope, Garrett County  
Belden R. Reap, Montgomery County  
Thomas Reid, Frederick County

William F. Renner, Baltimore City  
Philip L. Repetto, Jr., Pr. Geo. Co.  
Peter W. Rieckert, Dorchester County

Antonio M. Rivera, Anne Arundel Co.  
Samuel P. Scalia, Baltimore County

John F. Schaefer, President  
J. Thomas Schnebly, Montgomery Co.

Margaret Lee Sherrard, Baltimore Co.  
Arthur G. Siwinski, Past President

R. Kennedy Skipton, Prince Geo. Co.  
Gordon M. Smith, Montgomery County

Roland T. Smoot, Baltimore City  
Aaron C. Sollod, Baltimore City

William G. Speed, III, Council

Robert J. Thomas, Council

\*Theodore F. Toulon, Baltimore County

\*Richard F. Tyson, Baltimore City

Philip F. Wagley, Council  
Hugh W. Ward, Calvert County

H. Leonard Warres, Baltimore City  
Lawrence R. Wharton, Jr., Balto. City

\*J. Daniel Wilkes, Montgomery County  
Charles E. Wright, Frederick County  
N. Louise Young, Baltimore City



Present also were staff personnel.

### Invocation

Karl F. Mech, MD, Treasurer of the Faculty, gave the invocation.

### Announcements

The President made announcements dealing with the conduct of business at the session.

### Introduction of New Members

The President introduced the following new members of the House:

James B. Brooks, MD, Baltimore  
Philip W. Heuman, MD, Bel Air  
John H. Hornbaker, MD, Hagerstown  
Benjamin H. Minchew, MD, Columbia  
Francis J. Townsend, MD, Ocean City

### Minutes of Annual Session

The minutes of the House of Delegates of the May 12, 1971 and May 14, 1971 sessions having been distributed to all members and having been approved by the Executive Committee, were presented to the House for information.

### Peer Review Committee Report on Maryland Foundation for Medical Care

Arthur E. Cocco, MD, Chairman of the Peer Review Committee, on behalf of the Committee, offered the following ten recommendations which, after debate and amendment, were adopted as follows:

1. The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland approves the formation of a Maryland Foundation for Health Care.
2. That its organizational structure be developed, in concert with other providers of health services, with an invitation being extended to other organized medical groups, including health-oriented consumer groups, to join with the medical profession in this endeavor.
3. That appointment of the Board of Directors of the Maryland Foundation for Health Care be directly vested with the Council of the Medical and Chirurgical Faculty. In this manner, the Foundation would be a functioning body of the Faculty, just as various committees of the Faculty presently are.
4. That the Council or House of Delegates approve the draft bylaws, either as they are submitted or changed by either of these bodies, or approve them in principle, leaving final approval to the Board of Directors of the Foundation.

5. The members of the House of Delegates of the Medical and Chirurgical Faculty shall be the voting members of the Foundation; with the Council being authorized to act (as it currently is authorized to do) between sessions of the House of Delegates. In addition, the Faculty's Executive Committee be designated as officers of the Foundation with the authority to make decisions of immediate importance (as is currently their responsibility for Faculty affairs).

6. The Executive Director of the Faculty be the Chief Executive Officer of the Foundation.

7. Other deliverers of health care be invited to join the Foundation, with representation on the Board to be determined, after discussions with such groups.

8. That the purposes of the Foundation be adequately and clearly spelled out, with authority being given to the Council to approve the changes in bylaws, etc, as needed or required.

9. That sufficient funds for expenses involved in the development of the Foundation structure be advanced to the Foundation, with the understanding that as the Foundation becomes operational, charges be made to third parties for its activities; and that such funds would be repaid to the Faculty.

10. That the Faculty's Peer Review Committee play an active and vital role in the Foundation operation.

### Medical Economics Committee Report

In the absence of the chairman of the Medical Economics Committee, the Secretary, on behalf of the Committee, offered the following motion which, after debate, was adopted, there being more than two thirds in the affirmative, as follows:

*Resolved*, That the Council of the Medical and Chirurgical Faculty of Maryland be empowered and is hereby empowered to rescind the action of the House of Delegates, taken at the Annual Meeting in 1960, endorsing the St. Paul Companies as the official carrier of the Faculty for professional liability insurance program; and is also empowered to approve or endorse an alternative program if, in its opinion, such an alternative program is more desirable for the physicians of Maryland.



## 1970 Audit Report

Karl F. Mech, MD, Treasurer, presented the Auditor's statement for the year 1970. There being no objection, the auditor's statement was approved.

### Information 1970 Committee Reports

The following 1970 Committee Reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions or comments.

Report of the Delegates to the American Medical Association—Robert V.L. Campbell, MD, J. Sheldon Eastland, MD, Russell S. Fisher, MD, Annual Meeting 1970, Clinical Meeting 1970

Executive Director — Mr. John Sargeant

Library and History Committee and Finney Fund Committee — Paul F. Guerin, MD, and D. C. W. Finney, MD

Curator — Edwin David Weinberg, MD

Medical Annals — Leslie E. Daugherty, MD

Committee on Program and Arrangements — Arlie B. Mansberger, MD

Committee on Contractual Arrangements — J. Howard Franz, MD, Chairman

Editorial Board, *Maryland State Medical Journal*—C. Thomas Flotte, MD

Committee on Emotional Health — Exall L. Kimbro, MD

Finance Committee — Karl F. Mech, MD

Maryland Medical Service, Board of Trustees — J. Sheldon Eastland, MD, Chairman

Med-Chi Insurance Trust — Paul F. Guerin, MD

Medical Emergency Disaster Service Committee — (No committee appointed 1970/71)

Committee on Postgraduate Education, Preventive Medicine and Public Health — John Whitridge, MD

Public Relations Committee — Paul A. Mullan, MD

Mediation Committee — Lewis P. Gundry, MD  
Secretary — William A. Pillsbury, MD

Medicolegal Committee — Conrad Acton, MD  
Board of Medical Examiners — Elmer G. Linhardt, MD, Secretary/Treasurer

Medical Economics Committee — W. Kenneth Mansfield, MD

Legislative Committee — B. Martin Middleton, MD

Liaison Committee — James B. Brooks, MD

Medicine and Religion Committee — Martin L. Singewald, MD

Occupational and Environmental Health Committee—Carlos Villafana, MD

Professional Medical Services Committee — Morris J. Wizenberg, MD

Policy and Planning Committee — Arthur T. Keefe, Jr., MD

Woman's Auxiliary to the Medical and Chirurgical Faculty Report — Mrs. Raymond M. Yow

H.A.V.E.S. Program — Karl M. Green, MD, President (Hearing and Vision Early Screening Program)

Peer Review Committee — Arthur E. Cocco, MD, Chairman

Commission on Medical Discipline — John M. Dennis, MD, Chairman

Ad Hoc Liaison Committee to work with AFL/CIO Representatives — John F. Schaefer, MD, Chairman

Ad Hoc Committee on New Faculty Building—Russell S. Fisher, MD, Chairman

### Resolution 1S/71 Indiscriminate Use of Amphetamines

Manning W. Alden, MD, Chairman of the Council, on behalf of the Council, offered the following resolution which the House agreed to consider by a two thirds vote. The resolution was, after debate, adopted as follows:

WHEREAS, The indiscriminate use of amphetamines by the general public has assumed alarming proportions; and

WHEREAS, Almost total bans on the prescribing of amphetamines and methamphetamines in other areas of the country have resulted in a heavy reduction in the number of such prescriptions written; and

WHEREAS, The dispensing of all drugs by physicians is discouraged through the Physician/Pharmacy Code of Cooperation; and  
WHEREAS, It behooves every member of the medical profession to exert the utmost caution in prescribing or dispensing any drug with an abuse potential, be it

*Resolved*, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as stressing the cooperation of all physicians in the state in ensuring that prescribing of amphetamines and methamphetamines is restricted to truly recognized cases of medical need.

*Continued on page 88*



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**Warning:** Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

**Adverse Reactions:** Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain,

arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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**Prescribing Information—Composition:** Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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## MINUTES

*Continued from page 82*

### Resolution 2S/71 Commendation of HCAS and HCC Program

Dr. Alden, Council Chairman, on behalf of the Council, offered the following resolution for consideration of the House, which by a two thirds vote, the House agreed to consider. The resolution, after debate, was adopted as follows:

WHEREAS, This organization, in existence for the past 11 years, has proven itself to be of inestimable value both in reducing costs of audits previously conducted by different, independent organizations; and

WHEREAS, In 1968 recognizing the need for extensive and effective efforts to be expended in the areas of hospital cost controls, it expanded to include this function; and

WHEREAS, Since that time it has been successful in reducing costs in various hospital departments that otherwise may not have occurred; and

WHEREAS, Recognition of this effective hospital cost containment program is evident through a grant from the U. S. Department of Health, Education and Welfare for a continuation of the program and a refinement of techniques used therein; and

WHEREAS, Recognition by local authorities should be made of this effective activity; be it

*Resolved*, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland goes on record as commending the Hospital Cost Analysis Service for its activities and for the effective measures developed by the Hospital Cost Containment Service to ensure that hospital funds are used in an effective and cost-efficient manner; and

*Resolved*, That a copy of this resolution be sent to the following groups: Hospital Cost Analysis Service, Hospital Cost Containment Program, Maryland Hospital Association, Department of Health and Mental Hygiene, Maryland Blue Cross, Inc., Health Insurance Association of America, U. S. Department of Health, Education and Welfare, and the newly appointed Health Services Cost Review Commission.

### Resolution 3S/71

#### Use of Methadone

Dr. Alden, Council Chairman, offered the following resolution to the House which, by a two thirds vote, agreed to consider it. The resolution, after debate and amendment, was adopted and reads as follows:

WHEREAS, Methadone (Dolophine) is an accepted method of treatment for hard-core narcotic addicts; and

WHEREAS, Methadone (Dolophine) is a widely used drug for the purpose of detoxification of such addicts; and

WHEREAS, It is a well known fact that narcotic addicts easily feign illness, pain and withdrawal symptoms to prey upon the compassion of the physicians; and

WHEREAS, On occasion, physicians have proven susceptible to prescribing this drug for addicts without recognizing the serious problems they may be fostering; and

WHEREAS, Other suitable substitute drugs can be prescribed for legitimate cases needing a drug to alleviate pain; and

WHEREAS, It is deemed in the best interest of the public, as well as the physician population, to restrict access to this drug and see that it is used only for legitimate purposes; and

WHEREAS, Existing committees of the Medical and Chirurgical Faculty have been effectively controlling, as far as possible, any indiscriminate prescribing that is brought to its attention; and

WHEREAS, Such committees can and are willing to approve use of this drug, on request, for limited purposes and under strict supervision; be it

*Resolved*, That the Medical and Chirurgical Faculty of the State of Maryland, jointly with the Secretary of Health and Mental Hygiene, hereby requests all physicians in Maryland to cease use of this drug, except for controlled drug therapy programs that have a legitimate IND number; in cases where specific urgent medical need exists; and in cases where special exceptions are approved by the Secretary of Health and Mental Hygiene after the recommendation by committees of the Faculty, and be it

*Resolved*, That this action be disseminated to all physicians in Maryland so they are fully aware of this restriction on the use of Methadone (Dolophine); and be it



*Resolved*, That the Maryland Pharmaceutical Society be informed of this action so that pharmacists and pharmacies in Maryland will also be aware of the restriction on the use of this drug and will notify the Division of Drug Control, State Department of Health and Mental Hygiene so that a review of such prescriptions may be undertaken by the appropriate Faculty committee.

#### New Business

John B. DeHoff, MD, Program and Arrangements Committee chairman, made certain announcements regarding the Scientific program

scheduled for Puerto Rico, September 15-19; and also regarding the 1972 Annual Session, scheduled for Baltimore, May 3, 4, 5, 1972.

#### Request For Financial Assistance

Marshall Diamond, MD, Delegate from Montgomery County, asked that the Executive Committee give consideration to assisting financially the activities of the ophthalmologists in their legislative activity. This item was referred to the Executive Committee for its consideration.

The President, by general consent, declared the House adjourned *sine die* at 4:07 P.M.

William A. Pillsbury, MD, *Secretary*

### COMMENTS OF W. KENNETH MANSFIELD, MD, CHAIRMAN, MEDICAL ECONOMICS COMMITTEE, BEFORE THE HOUSE OF DELEGATES, SEMIANNUAL SESSION, SEPTEMBER 11, 1971

*Mr. President and Members of the House of Delegates:*

All of us have been experiencing a sharp increase in the premiums we pay for professional liability insurance during the past two or three years. On June 1, an increase of almost 100% took place in the annual premium rate, particularly as these premiums apply to Classes III through V. On top of this, the premiums for the so-called umbrella type policy have been tied into the premium structure for the basic \$100,000/300,000 policy so that as premiums for the basic coverage increase, so do the premiums for the umbrella type coverage for the professional person. Let me give you an example of how this escalation has taken place:

CLASSES	I	II	III	IV	V	
YEAR	\$ 96	\$168	\$ 287	\$ 383	\$ 479	Basic \$100/300
1969	98	98	140	140	140	Umbrella
	<u>194</u>	<u>266</u>	<u>427</u>	<u>523</u>	<u>619</u>	Total
YEAR	163	287	490	653	816	Basic \$100/300
1970	119	155	212	258	305	Umbrella
	<u>282</u>	<u>442</u>	<u>702</u>	<u>911</u>	<u>1121</u>	Total
YEAR	239	419	907	1210	1512	Basic \$100/300
1971	146	201	380	482	585	Umbrella
(CURRENT RATE)	<u>385</u>	<u>620</u>	<u>1287</u>	<u>1692</u>	<u>2097</u>	Total

In Class V, for instance, what the physician previously obtained for \$619 in 1969, he paid \$1,121 for in 1970. This year he is paying almost \$2,100.

Up until this current year, we have been unable to interest any other insurance carrier to underwrite a program for Maryland physicians. There has been sporadic interest by the Aetna Company to underwrite the so-called good risk, Classes I and II, but this firm did not wish to write the other high exposure fields such as Classes III through V.

As can be found in the Annual Report of our Committee, printed in the July issue of the *Maryland State Medical Journal*, we have been exploring alternatives to insurance through organized carriers. This is an avenue we are still actively exploring but it requires considerable thought and study before a recommendation can be made in this regard.

In the past six months, however, we have been pleased to see that carriers other than the St. Paul Companies are now interested in discussing the feasibility of carrying our members as a group. There are certain features your Committee believes essential to the success of any group. They are very succinctly listed in the proposal now under consideration within your committee as advanced by the Continental of North America, through the AMA. These are:



1. Guarantee of availability.
2. Profit sharing formula and investment income credit.
3. Full financial disclosure of all aspects of the plan.
4. Detailed statistical data on membership within the plan.
5. Loss prevention program specifically designed for the Association.
6. Continuing education programs.
7. Research on claim data to uncover contributing factors and recommend corrective action as well as provide input to loss prevention programs.
8. Development of eligibility standards with the profession itself; with continuing dialogue in this area to provide exceptions to the general eligibility standards such as special exclusions, rates or modifications in coverage.
9. Evaluation and recommendation as to the existence of liability and further actions it is felt should be taken.
10. Provision of data to the Peer Review Committee for its action in connection with professional incompetency.

It is extremely important for our Committee to be aware of all cases, or incidents that might lead to cases, as they occur. In this manner, we would be able to take corrective action either against a physician, a procedure, or practices. This we are striving to obtain from our present carrier and, should any change be made, will insist on before any agreement is concluded.

This is the purpose behind the resolution before you today.

## **REPORT OF THE MEDICAL ECONOMICS COMMITTEE TO THE HOUSE OF DELEGATES** **September 11, 1971**

*Mr. President and Members of the House of Delegates:*

As you know from the Annual Report of this committee, we have been struggling for some time to find a solution to the increasingly difficult problem of professional liability insurance.

Various proposals have been considered by your committee, but all have been rejected for one reason or another.

Your committee has currently under consideration proposals from the Continental Insurance Company of North America, as well as from the Hartford Insurance Company. It is anticipated that other high quality companies may also make proposals to the committee. At the present time, the only recommendation the committee has is as follows:

*Resolved*, That the Council of the Medical and Chirurgical Faculty of Maryland be empowered and is hereby empowered to rescind the action of the House of Delegates, taken at the Annual Meeting in 1960, endorsing the St. Paul Companies as the official carrier of the Faculty for professional liability insurance program; and is also empowered to approve or endorse an alternative program if, in its opinion, such an alternative program is more desirable for the physicians of Maryland.

This resolution is required because the Council, as you know, does not have the authority to reverse any action of the House of Delegates. In the event that a suitable alternative becomes available, it is deemed desirable not to wait until the Annual Meeting, 1972 to effect any such change.

Respectfully submitted,  
W. Kenneth Mansfield, MD, Chairman  
Arthur Baitch, MD  
J. Tyler Baker, MD  
Fred Cole, Jr., MD  
Thomas Crawford, MD  
Samuel M. Lumpkin, MD  
Philip W. Mercer, MD  
Alfred S. Norton, MD  
Hans Wilhelmson, MD





PAUL F. GUERIN, MD, CHAIRMAN  
Library and History Committee  
ELIZABETH SANFORD  
Librarian

## library

# Reflections=1849 to 1891

The library is fortunate to have in its possession early documents, manuscripts, and other material pertaining to the origin and development of the Medical and Chirurgical Faculty of the State of Maryland.

It has been my good fortune to work with much of this material as part of the Ash project under the supervision of Mrs. Sanford and Lee Ash. I recently found, on a dusty shelf in the safe, a large record book, containing the minutes of

the Faculty from 1849 to 1891. Attached to the manuscript was an original sketch written by the late Dr. Joseph Ruhrah concerning the acquisition and importance of the records.

The following is a complete reproduction of Dr. Ruhrah's composition. Members are invited to come to the library and examine this most interesting manuscript.

Michael A. Murray

Those of you who are familiar with Cordell's Annals may remember that he passed over a period from 1859 to 1866, stating that there was no local society in this city. In 1866 the Baltimore Medical Association was formed, which lasted for a number of years and was eventually merged with the Baltimore Medical and Surgical Society. The Medical and Chirurgical Faculty at this time led to the formation of another Society called the Medical Faculty of the District of Baltimore. This was organized under an act of the General Assembly, but after they attained some 217 members, it was found that the act was without an enacting clause and hence invalid, and there was an immediate collapse.

When Dr. Cordell wrote his Medical Annals he was convinced that there had existed a minute book covering a period of years, but where this book was was a mystery. With the death of Dr. Robert T. Wilson his medical books came to our Library, and in looking them over it was found that there was a large record book containing the minutes of the Faculty from 1849 to 1891. Dr. Wilson was recording secretary for a number of years, but just how he obtained possession of this book is not clear.

The interesting part of the record deals with the Civil War period. On June 4, 1859 Dr.

Kemp started to read his report, but it was discontinued on account of fatigue. The Faculty adjourned until 12 noon on the following Monday, when the first business in order shall be the continuation of the report. The following was noted on June 6, 1859: "No quorum present, the Faculty adjourned to meet at 12 N tomorrow, Tuesday. Tuesday, June 7, 1859, no quorum present Faculty adjourned. Dr. Henry M Wilson, Recording Secretary." The meetings of 1860 and 1861 fared in like manner.

In 1862 a note was made that there was a modification of the Charter of the Maryland Legislature requiring five instead of 15 to constitute a quorum. This resulted in meetings which were evidently very lame affairs. There was a committee appointed, Dr. George C.M. Roberts, Chairman. In the report he speaks of the condition of the organization and what measures are necessary for its success. Under this head the committee would say emphatically *Money*, and they urged the necessity of adopting at once some financial measure that would secure a regular annual income. The library could be made attractive by adding valuable books and a point of union to the members. This appears to be the only means left to the Faculty whereby it can hope to accomplish anything in the promotion



and diffusion of medical and chirurgical knowledge. This report was signed by William M. Kemp and John F. Monmonier.

The officers of 1862 were: President, Dr. George C.M. Roberts; Vice-Presidents, Drs. Dunbar, Kemp and Donaldson; Treasurer, Dr. Thomas Owings; Rec. Secretary, Dr. Henry M. Wilson; Asst. Rec. Secty., Dr. William I. Wroth; Corresponding Secty., Dr. G.E. Morgan; and Library Directors, Drs. Chew, Morgan, Riley, Kinneman, and Boardly.

There was a ground rent on the Faculty in 1863, and a strenuous effort was made to redeem same, and \$887.50 was contributed by 50 contributors, mostly from the city. Drs. S.K. Handy, N.R. Smith, John Buckler, John P. Mackenzie, and W. Fisher each gave \$50. The remaining contributions vary from \$2.50 to \$25.

To go back a little, we find that in 1858 there was a tax of \$2 per member for the use of the Library. Apparently the finances of the Faculty were kept up by the fees received from granting licenses to practice. In 1876 a tax of \$6 for the city members and \$3 for the county members was made for the benefit of the library, and at this particular period a man could be a patron of the library for the small sum of \$100.

To continue the status of the Faculty in the sixties, in 1862 under the date of June 12, "The present status of the Faculty shows in all its phases a condition of extreme depression" and we quote "The first serious inroads upon the revenue and membership of the Faculty is found in the legal exemption of the graduates of the University of Maryland from the necessity of procuring the license of the Faculty. As the largest portion of the physicians in the State were graduates of Schools chartered by the State and therefore exempt as specified, they did not become members of the Faculty, and as a consequence the income and prestige of the Medical and Chirurgical Faculty were greatly damaged."

Another plaintive note was struck by the Recording Secretary stating in the same minutes, "The want of interest in the meetings and affairs of the Faculty may be accounted for in various ways, but they deem it necessary to rehearse the divers reasons specified, deeming the palpable fact sufficient for all useful purposes. It is conceded by everyone with whom the committee has conferred that the profession should sustain this organization, and give it such efficiency as to realize advantages to its membership. The committee need not recite the benefits desirable from a well constituted organization encouraged and sustained in a liberal and honorable profession."

Some of us reading the Bulletin may be struck by the way this cry has been carried down the years since the beginning of the Faculty by the latest expression of our Treasurer, Dr. Brack, and I ask you to heed his call.

Dr. John Ruhrah

## NEW ACCESSIONS - BOOKS

(arranged by subjects)

### ANATOMY

Sidman, Richard L.

**Atlas of the Mouse Brain and Spinal Cord**, by Richard L. Sidman, Jay B. Angevine, Jr. and Elizabeth Taber Pierce, Cambridge: Harvard University Press, 1971, QL 937 S 5.

### CARDIOVASCULAR SYSTEM

Phibbs, Brendan

**The Human Heart; a Guide to Heart Disease**, with contributions by Lane Craddock and others, 2d ed, St. Louis: Mosby, 1971, WG 200 P 4.

### HOSPITALS

Maryland State Department of Health and Mental Hygiene.

**Survey Emergency Ambulance Service in Maryland**. Baltimore: State Department of Health & Mental Hygiene, 1971, WX 215 M 3.

The Pennsylvania Medical Society. Commission on Emergency Medical Services.

**Emergency Medical and Health Services in Pennsylvania**, LeMoyne, Pa.: The Society, 1971, WX 215 P 4.

### MEDICAL PROFESSION

American Medical Association. Center for Health Services Research and Development.

**Reference Data on Socioeconomic Issues of Health**, Chicago: AMA, 1971, W 76 A 5.

American Medical Association. Council on Medical Education. Ad Hoc Committee on Education for Family Practice.

**Meeting the Challenge of Family Practice**, Chicago: AMA, 1966, W 89 A 5.

American Medical Association. Office of the General Counsel.

**Sale or Disposition of a Medical Practice**, Chicago: AMA, 1971, W 80 A 5.

Friends Medical Science Research Center, Inc.

**A Survey of Professional Liability Incidence in Maryland**, Baltimore: Medical and Chirurgical Faculty of the State of Maryland, 1971, W 700 F 7.

### MICROBIOLOGY

**Manual of Clinical Microbiology**, edited by John E. Blair, Edwin H. Lennette and Joseph P. Truan, Bethesda: American Society for Microbiology, 1970, QR 46 M 3.



## MUSCULOSKELETAL SYSTEM

De Palma, Anthony F.

**The Management of Fractures and Dislocations**, 2d ed, Philadelphia: Saunders, 1970, WE 17 D 4.

## OTORHINOLARYNGOLOGY

Tobias, Jerry V.

**Foundations of Modern Auditory Theory**, New York: Academic Press, 1970, WV 270 T 6 v1.

## PEDIATRICS

Hughes, James Gilliam

**Synopsis of Pediatrics**, 3d ed, St. Louis: Mosby, 1971, WS 100 H 8.

## PHYSIOLOGICAL CHEMISTRY

**Reference Data on Socioeconomic Issues of Health**, Review of physiological chemistry. Los Angeles, Calif. Lange Medical Publications, 1971, QP 514 R 4.

## PHYSIOLOGY

Jokl, Ernst

**Exercise and Cardiac Death**, editors: E. Jokl and J.T. McClellan. Baltimore: University Park Press, 1971, PT 260 M 4, v5.

**Physical Activity and Aging**, edited by D. Brunner and E. Jokl, introduction by Philip Noel Baker, prefaces by Z. Faifar and P.D. White. Baltimore: University Park Press, 1970, QT 260 M 4, v4.

## PRACTICE OF MEDICINE

Cecil, Russell L.

**Cecil-Loeb Textbook of Medicine**, edited by Paul B. Beeson and Walsh McDermott, 13th ed, Philadelphia: Saunders, 1971, WB 100 C 4.

## PUBLIC HEALTH

American Medical Association. Council on Medical Service.

**Health Maintenance Organizations (HMO's)**, report presented by Guy A. Owsley, Report D, Chicago: AMA, 1971, WA 540 A 5.

U. S. Health Services and Mental Health Administration. Federal Health Programs Service.

**Automated Multiphasic Health Testing**, edited by Richard K. Hsieh, Faith Dean Gilroy, Melvyn Greberman, Baltimore: USPHS, Health Services Research Branch, 1971, WA 20.5 U 6.

## MISCELLANEOUS

American College of Surgeons

**Cancer Programs Approved**, Chicago: American College of Surgeons, 1971, reprinted from Bulletin of the American College of Surgeons, April 1971, QZ 266 A 5.

American Medical Association. Scientific Publications Division.

**Style Book and Editorial Manual**, Chicago: American Medical Association, 1971, WZ 345 A 5.

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# TICKS

KENNETH L. CRAWFORD, DVM, Chief

Division of Veterinary Medicine  
Maryland State Department of  
Health and Mental Hygiene

There are about 300 species of bloodsucking parasites of man and other mammals, birds, reptiles, and amphibians. Nearly all are capable of biting man. A few, including ticks, are important in the transmission of disease to man.

Important human diseases transmitted in America by ticks include:

- A. Rickettsial Diseases: Rocky Mountain Spotted Fever and Q-Fever
- B. Viral Diseases: Equine encephalitis (western strain) and yellow fever
- C. Bacterial and Spirochaetal Diseases: Tularemia and Relapsing fever
- D. Protozoan Disease: American trypanosomiasis
- E. Tick Paralysis: may be caused by *Dermacentor variabilis*, *Amblyomma americanum*, and *Amblyoma maculatum* KOCH in the Eastern and Southern United States

Protozoan diseases transmitted only to animals include: Texas fever of cattle, Piroplasmosis of dogs, and European cattle fever.

Ticks of importance to man in Maryland are characterized by having reddish, mahogany, or brown color. Their bodies are covered by a hard shell which protects their vital organs. Adult ticks have four pairs of six-jointed legs that usually terminate in hooks. These hooks make tick removal difficult in hair covered areas. Ticks utilize an effective cutting organ for insertion of the blood-sucking device, the hypostome. From one-half to two hours is required before the tick

injects any infective material from its stomach contents into its host.

Understanding the tick's life cycle is important since control procedures require interference in the cycle. The important ticks of Maryland require three different hosts. These ticks have a complete life cycle which includes egg, larva, nymph, and adult stages. Only about 30 of the six to eight thousand eggs which are laid on the ground reach maturity. The eggs hatch and the larva migrate to vegetation and await the first host. If successful, the larva engorges on blood, falls off, and molts to the nymph stage. After the nymph engorges on the second host, it falls off and molts. The adult then attaches to the final host for feeding. The adult and nymph have a feeding period of three to 12 hours. Adult ticks can survive up to four years without feeding. Cold weather forces the nymph and adult into hibernation while direct sunlight, heat, drying, and excessive rainfall retard all stages of tick development.

## Maryland Ticks

Four ticks are common to Maryland. The most prevalent and dangerous is *Dermacentor variabilis*. This tick is found throughout America and is known as the "American dog tick" or woodtick. In Maryland, it is the usual vector for Rocky Mountain Spotted Fever. In areas where Rocky Mountain Spotted Fever has

### DIFFERENTIAL IDENTIFICATION OF THREE COMMON MARYLAND TICKS

	D. variabilis (American dog or wood tick)	R. sanguineus (brown dog tick)	A. americanum (lone star tick)
Basis capitula (head)	rectangular dorsally	hexagonal dorsally	variable
Spiracles	sub oval or coma- shaped	elongated coma- shaped	sub oval or coma-shaped
Coxae	male coxae increase I to IV with IV much larger	first is bifid with two strong spurs	absent
Scutum (shield)	ornate	inornate	ornate
Adanal plates	absent	on males (ventral surface)	absent on males



been diagnosed, studies show that up to 2% of adult ticks may be infected. *Rickettsia rickettsia*, the cause of the disease, is thought to be maintained in nature by transovarial and transstadial infection in ticks as well as by the tick-animal-tick cycle. In the eastern United States, the dog plays an important host role in the life cycle of the tick. In dogs, production of clinical signs and recovery of the rickettsia has been accomplished experimentally. However, dogs have not been found to be naturally infected.

Although this tick is distributed throughout the United States, it is of particular importance as a disease vector east of the Rocky Mountains. It is commonly found on the Atlantic Coast from Massachusetts to Florida.

This tick varies in color from chestnut to a chocolate-brown and has characteristic white markings. Its outer shell contains depressions with tactile hairs. The principal host is the dog although man, cattle, horses, hogs, sheep, and large fur-bearing animals may be attacked. It is significant that the hosts of the immature tick are field mice and other small rodents. In Maryland, the adult ticks are prevalent in the spring and summer, sometimes disappearing by early August. It is suggested that the increased numbers of pet animals in urban areas contribute to extending the active phase of the life cycle beyond the spring and summer months.

Greater thermal pollution of the environment may extend the period of activity of ticks. If this occurs, then more suitable biological safeguards may be provided to control this potentially dangerous parasite.

### Dog Tick

The second most common tick in Maryland is *Rhipicephalus sanguineus*. It is commonly known as the "brown-dog tick." This tick is more common in the southern United States. Like the American dog tick, it is being found in increasing numbers in northern states. All three stages of this tick are found in homes and other areas where dogs live. It usually parasitizes only the dog and is not considered to be an important vector of human disease.

The "lone star" tick, *Amblyomma americanum*, has been found recently in Harford County and in southern Maryland. This tick was found on white tailed deer, a household pet (dog), and unattached on a man. The larva, nymph and adult stages attack man, wild and domestic animals, and birds. The lone star tick may transmit Rocky Mountain Spotted Fever and tularemia and occasionally causes tick paralysis in man and dogs.

### Tick Paralysis

To prevent tick paralysis and other diseases, ticks should be immediately and carefully removed. Avoid contaminating the skin with the infective contents of crushed ticks. Coating the body of the imbedded tick with nail polish remover, oil or grease, or by touching the tick with the hot tip of an extinguished match encourages detachment. Tweezers or paper tissues can be used to safely remove ticks. Contrary to popular opinion, the head will not remain imbedded in the skin if the tick is carefully withdrawn. After removal, the wound should be washed with soap and water or a common antiseptic. Ticks should be removed from the household. A recommended procedure is to flush them down the toilet or garbage disposal.

### Control Measures

It is significant that the brown dog tick, *Rhipicephalus sanguineus*, requires the dog as host for all three stages of its life cycle. In infested homes and kennels, the tick molts and can reinfest the same or other dogs. To prevent infestation, housing areas must be thoroughly cleaned and an effective residual insecticide applied. The directions on insecticide labels are important and must be followed carefully. Recommended residual sprays include: 1.1% Baygon, 1% Diazinon, 0.5% Dursban, 2.25% Entex, 2-3% malathion and 2% ronnel. Either oil or water bases are effective.

Particular attention should be given to the dog's sleeping areas, spaces adjacent to baseboards, door and window casings, and beneath the edges of floor coverings. Furniture usually requires treatment. All dogs on the premises should be washed and a solution of a recommended tick-cide applied. Washes are preferred since penetration of the hair is more complete. Recommended products include washes of 1% coumaphos (Co-Ral), 0.03% lindane, or 0.5% malathion; dusts of 1% lindane, 2-3% chlordane, 5% carbaryl (Sevin), 0.5% coumaphos, 1% trichlorfon (Dipterex), or 3-5% malathion.

If ticks appear on the dog or premises after four weeks have elapsed, retreatment is required. At least one retreatment is usually necessary.

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**Peter C. Luchsinger, MD**

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Associate Professor of Medicine  
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**December 17, 1971 12:30 PM**

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Associate Professor of Medicine  
Johns Hopkins University School of Medicine

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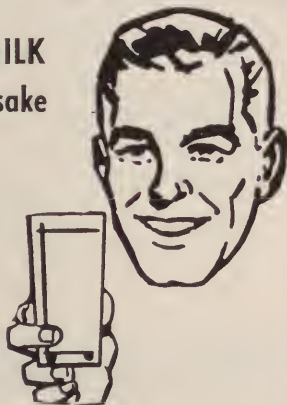
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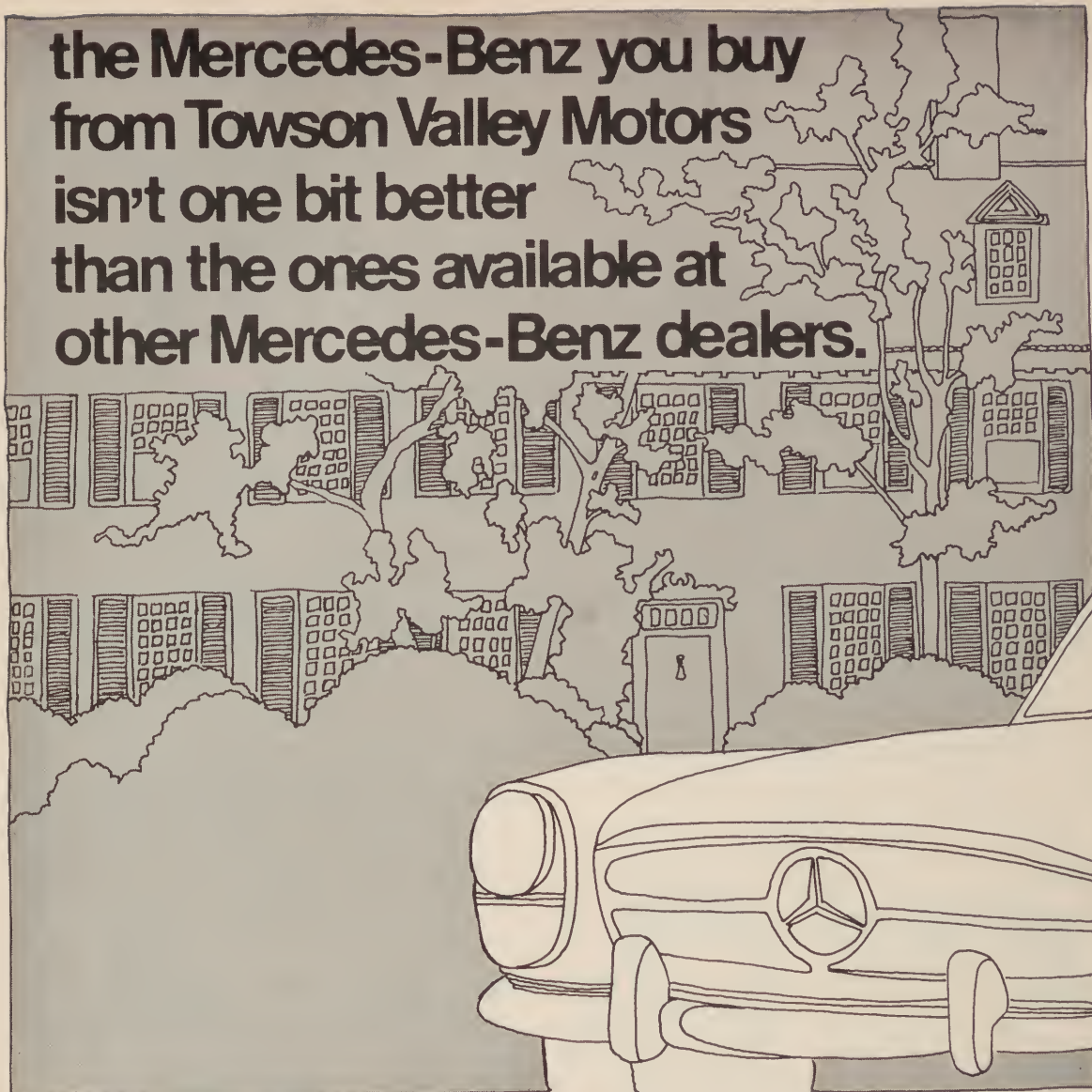
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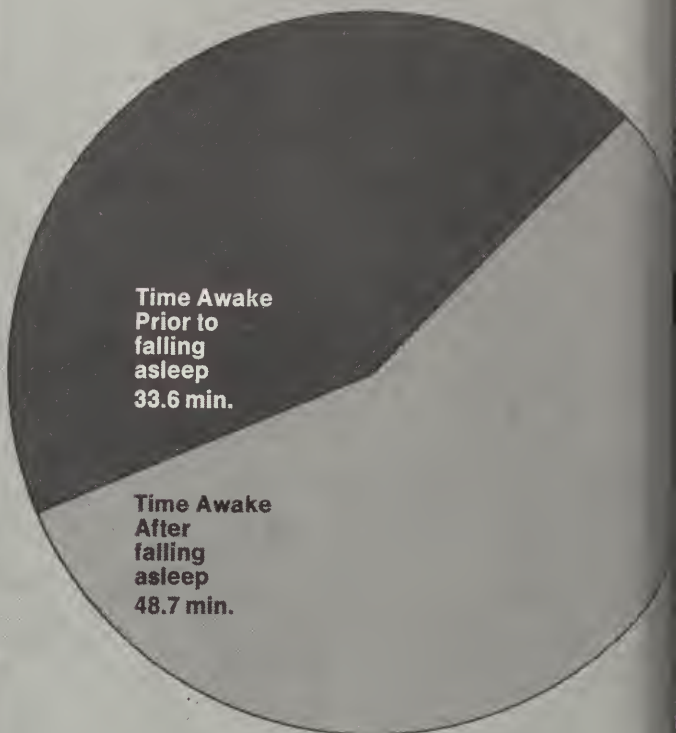
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**References:** 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

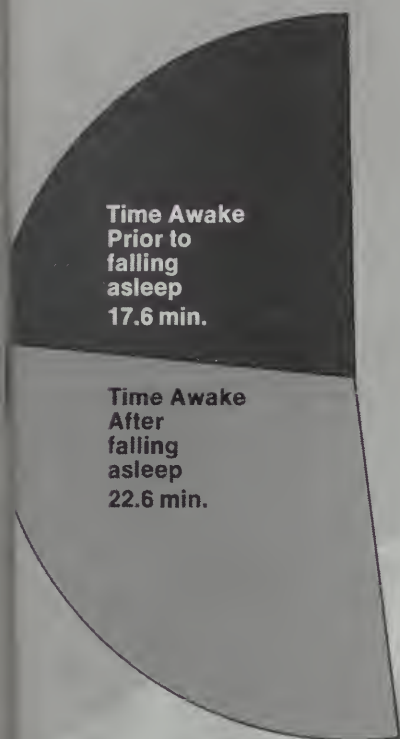
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**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

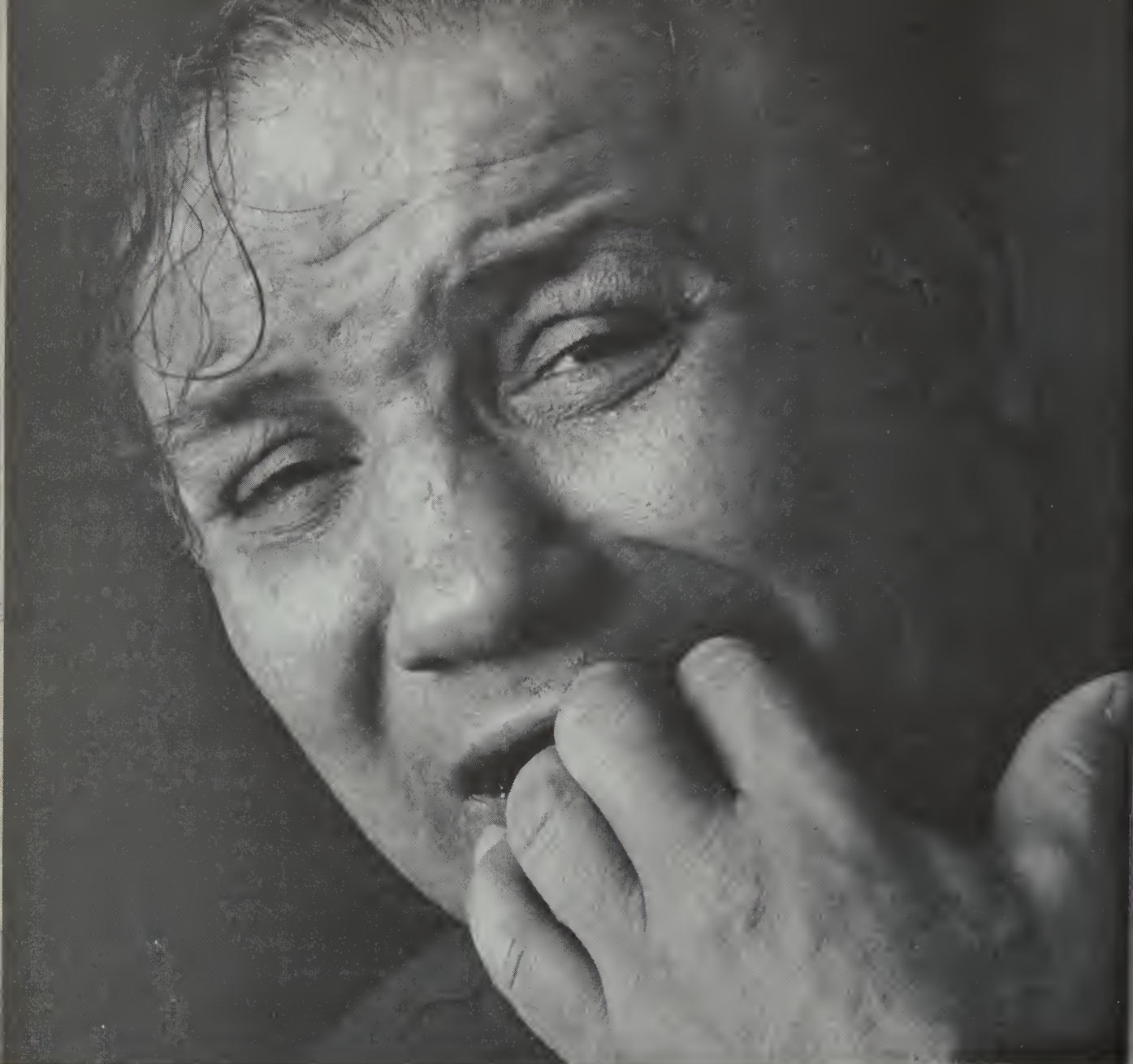
**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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NUMBER 12

## ARTICLES:

### Changing Attitudes and Practices Concerning Abortion:

**A Sociomedical Revolution, Alan F. Guttmacher, MD ..... 59**

"My purpose is to trace landmarks in the history of abortion and then give my reactions to some of them. Finally, I would like to discuss the extraordinary experience we are having with abortion in New York since the law was repealed."

### Replantation of Amputated Extremities: Present Status,

**G. Rainey Williams, MD ..... 64**

"In May 1962, an amputated human extremity was successfully reattached for the first time. The patient was a 12-year-old boy who sustained amputation of the right arm in a train accident. He was taken to the Massachusetts General Hospital where Dr. Ronald Malt assembled a surgical team and reattached the extremity. As is usually true, the MGH success was the culmination of many years of interest and research in the field of replantation. Numerous legends, caricatures, and crude accounts demonstrate that for several centuries, men have been interested in replanting amputated parts. It is hardly surprising that early attempts were not successful."

### Medical Knowledge Self-Assessment Program, Edward C.

**Rosenow, Jr., MD ..... 69**

"After considerable study, several committees of the American College of Physicians concluded that physicians want to learn and to improve their skills. They would also like to know their deficiencies and they need careful reassurance. This program was developed to fulfill these needs and to protect the members of the College from obsolescence of knowledge. It will also protect them against various drives for quality control such as relicensure and recertification. If these drives do in fact become compulsory, self-assessment tests will certainly be a good way to prepare for them."

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**ON THE COVER:** An Aaron Sopher sketch of the Gatehouse entrance to The Sheppard and Enoch Pratt Hospital gives a Christmas-like look to this issue. It also inaugurates a series of front covers saluting Maryland hospitals.



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## THE SHEPPARD AND ENOCH PRATT HOSPITAL

Beginning with this issue, the Medical and Chirurgical Faculty of the State of Maryland, through the *Maryland State Medical Journal*, will salute Maryland hospitals. This will be done through our front covers and capsule histories.

The series is kicked off with a salute to The Sheppard and Enoch Pratt Hospital, located in Towson.

It is a 270-bed, private, not-for-profit, nonsectarian, psychiatric hospital founded in 1853 by Moses Sheppard and further endowed in 1896 by Enoch Pratt.

Sheppard-Pratt's educational program offers to residents an important opportunity for learning the art of modern psychiatric practice. It also maintains an affiliation with a number of nursing schools, an outpatient department, a child guidance clinic, and psychological testing which serves hundreds annually.

There are over 60 doctors on fulltime call and many consultants. The hospital is located in Towson in Baltimore County.

Robert W. Gibson, MD, is Medical Director.

### The Gingerbread House

The Gatehouse on North Charles Street in Towson, eight miles north of central Baltimore, which forms the entranceway to The Sheppard and Enoch Pratt Hospital, stands as a symbol of friendliness and peace. Patterned along the lines of a Swiss chalet, it is a double house,



divided in the middle by a bolted door separating the two attic rooms that form an arch over the driveway.

Passing through the iron gates under this arch gives a sensation of stepping into a fairytale. The old trees, the secluded little gardens on each side of the house, a chance black crow stealing off to a low branch cause the intruder to glance over his shoulder in spite of himself to see if the gingerbread witch really lives there.

But alas! No such luck! It is not a gingerbread house, but a very real one, made of lasting granite quarried from the farm itself. Originally a 340-acre farm known as Mt. Airy, it was purchased with money left by a Quaker merchant and philanthropist, Moses Sheppard, "to care for those with mental aberrations who were unable to care for themselves."

On closer scrutiny, one finds that each side of the structure is not actually symmetrical but, surprisingly, a three-bedroom house. One is roomier than the other, with an extra room on the first floor, and with a larger hallway and closet space. Both are bright and cheerful, with high ceilings and arched windows.

Each unit has its own attractive porch, one leading to a patio, the other overlooking a garden.

The occupants are caretakers for the hospital grounds and roads, and have lived there for most of their lives.

The old quilts on the beds, the antique furniture, and the two old oil lamps in the attic bring to mind the day of 108 years ago when construction on the gatehouse was begun. Its reason for existence is the same now as then—its charm and hospitality that increase with each passing year.

---

### Competition Open For Medical Art

Anyone in the health care field (physician, medical student, nurse, pharmacist, technician, veterinarian, dentist) may now enter the annual SAMA-Eaton Medical Art Award Competition, thanks to newly expanded entry classifications.

In addition to cash prizes and plaques, winning entries receive national attention through the traveling Medical Art Salon, a display of top winners. The salon premieres at the Student American Medical Association (SAMA) convention, is shown at the AMA convention, and then tours medical care institutions throughout the United States.

Full details on the rules, awards, and application requirements, plus official application forms, are available from SAMA, 1400 Hicks Road, Rolling Meadows, Ill. 60008. Entries must be received by January 15.



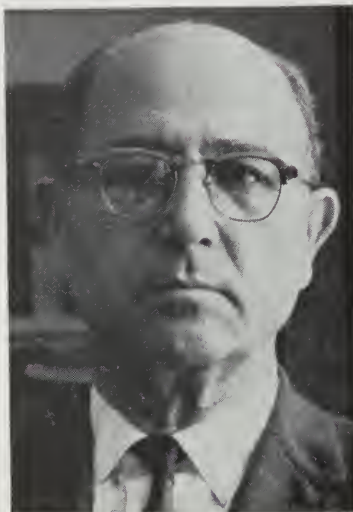
# Doctors in the News

**Jacob H. Conn, MD**, Assistant Professor Emeritus of Psychiatry and lecturer in hypnosis at The Johns Hopkins University Medical School, received the 1971 Milton H. Erickson Award of Scientific Excellence for Writing in Hypnosis. The award was made at the 14th Annual Meeting of the American Society of Clinical Hypnosis in Chicago in October.

Dr. Conn is the recipient of every award in medical hypnosis presented by the Society. He received awards for the best paper in Scientific and Clinical Hypnosis in 1960 and 1968; the 1961 Raginsky award for Leadership and Achievement as a "distinguished psychiatrist, teacher, scientist, and pioneer in hypnotherapy"; and the 1964 Schneck Award to the physician who made significant contributions to scientific hypnosis. He also is the recipient of the 1965 SCEH Presidential Award for his "outstanding work in the field of hypnosis over a period of 25 years," and the first gold medal award in 1970 for "scientific achievement for his outstanding professional contributions in the field of scientific hypnosis."

Dr. Conn is past president of the Society for Clinical and Experimental Hypnosis and of the American Board of Medical Hypnosis. He is the author of 110 scientific papers and past president of the Maryland Association of Private Practicing Psychiatrists. He was the first psychiatrist in Maryland to be certified by the American Boards of Psychiatry and Neurology, Child

Psychiatry, and Medical Hypnosis. He has been in the private practice of psychiatry since 1933.



**Dr. Conn**

**Charles Upton Lowe, MD**, FAAP, scientific director, National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, has received the 1971 Clifford G. Grulee Award for outstanding service to the American Academy of Pediatrics. The award was made at the Academy's annual meeting in Chicago in October.

He was honored for his 14 years of service with the AAP Committee on Nutrition, and particularly for his contributions as chairman of this committee from 1963 to 1969. He has been at NIH since 1968.

\*\*\*

During the Clinical Congress of the American College of Surgeons October meeting in Atlantic City, 36 Maryland surgeons were among the 1,475 inducted as new Fellows (members) of ACS.

Fellowship, a degree entitling the recipient to the designation "FACS" following the doctor's name, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one of the branches of surgery, and who give evidence of good moral character and ethical practice.

Marylanders so honored included:

**Steven J. Abramedia**  
**Comdr. David J. McMahon,**  
**MC USA**  
**Donald M. Barrick**  
**Hugh G. Beebe**  
**Edward W. Campbell, Jr.**  
**Charles M. Henderson**  
**Robert G. Hennessy**  
**Arthur J. Jasion**  
**Emil Kfoury**  
**Stanley A. Klatsky**  
**Ferdinand S. Leacock**  
**Robert M. Ollodart**  
**M. Ahmad Sarshar**  
**Kenneth F. Spence, Jr.**  
**Abraham M. Karr**  
**O. Riley Boone**  
**Paul B. Chretien**  
**Capt. William J. Fouty,**  
**MC USN**  
**John A. Dowling**  
**Edwin R. Lamm**  
**Alfred L. Lapin**  
**Bertram Weisbaum**  
**Lt. Col. Alvin L. Larson,**  
**MC USA**  
**Robert A. Smith**  
**Norman Rogers**  
**James R. Appleton**  
**John R. Marsh**  
**Anna M. L. Van Rooy**  
**Lee P. Haacker**  
**Edward C. Werner**  
**William B. Hagan**  
**Brooke A. Beyer**  
**Gene V. Aaby**  
**H. Peter James**  
**Arthur Litofsky**  
**Lorenzo Marcolin**

Congratulations to all of you!



**George D. Lawrence, MD**, has been appointed chief, Section of Endocrinology and Metabolism in the Department of Medicine, St. Agnes Hospital, Baltimore. He becomes the first such fulltime chief in the hospital's history.

Prior to joining the St. Agnes staff, he served as head of the Division of Endocrinology at the United States Air Force referral hospital at Andrews Air Force Base in Washington.

A native of New York City, Dr. Lawrence received his BS degree from Hobart College, Geneva, N.Y., and his MD degree from Tufts Medical School in Boston. He served an internship and completed his residency in medicine at the University of Maryland in Baltimore. This was followed by a two-year fellowship in endocrinology at The Johns Hopkins Hospital.

\*\*\*

**J. Parran Jarboe, MD**, who also serves as Secretary of the Charles County Medical Society, has been elected President of the Maryland Chapter of the American College of Surgeons. **B. Martin Middleton, MD**, Baltimore City, is the new Vice-President.

\*\*\*

Word has been received that **Louis M. Damiano** and **James C. King** have incorporated their practice under the name of "Louis M. Damiano, James C. King, MD, PA." They are located at 6005 Landover Road in Cheverly.

\*\*\*

**Mark Contardo**, student at The Johns Hopkins University School of Medicine, has been awarded a Medical Student Scholarship by the Southern Medical Association. He was among 26 so

chosen for these scholarships which are conferred annually to provide assistance to first-year medical students of superior ability.

\*\*\*

The Medical and Dental Society of Rosewood State Hospital has bestowed a lifetime membership on **Jose R. Andreu, MD**, Vice-President, as he leaves to go into retirement. Formerly active in Cuban public affairs, he came to Rosewood in 1964. At a formal reception, he was presented with an engraved silver tray and lifetime membership.

\*\*\*

**Chris P. Tountas, MD**, Baltimore, has been elected to Fellowship in the American Academy of Orthopaedic Surgeons.

**Raymond E. Jordan, MD**, Baltimore, received a first-place award for his Conservation of Hearing in Children otolaryngology exhibit at the recent American Academy of Ophthalmology and Otolaryngology annual meeting.

\*\*\*

At the recent annual meeting of the medical staff of South Baltimore General Hospital, **Ernie Maher, MD**, was elected Vice-Chairman and **C. C. Chiu, MD**, Secretary-Treasurer. These physicians were elected members of the Medical Executive Committee: **Robert Goldstein**, **Bernard Karpers**, **Mustafa Onal**, and **Leopoldo Salazar**. **Chris Papadopoulos, MD**, Chief of Cardiology, continues as Medical Staff Chairman for another year.



**DOCTORS HONORED**—Damian P. Alagia, MD, second from right, a member of the St. Agnes Hospital (Baltimore) attending staff, was honored recently by Seton Psychiatric Institute for his 44 years of service there at a special retirement dinner. Also honored and standing with Sister Anne William, administrator of Seton are: **Leo H. Bartemier, MD**, the medical director, and **Walter O. Jahrreiss, MD**, director of continued treatment service. The three doctors were honored for 97 years of combined service to the institute. In addition to Dr. Alagia with 44 years, Dr. Bartemier served 16 years, and Dr. Jahrreiss 37 years.



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# executive director's newsletter

December 1971

## RESOLUTIONS FOR ANNUAL MEETING

Resolutions for consideration of the House of Delegates at the annual session, May 3, 4, 5, 1972 must be received in the Faculty office prior to Wednesday, March 8, 1972.

Date for Reference Committee hearings will be announced at a later time.

## PUBLIC SPEAKING COURSE

Arrangements are being completed for an all-day public speaking training session to be held in the Faculty building on

Thursday, April 20, 1972

Reservations are limited to 30 persons and will be made on a first-come, first-served basis. Individuals interested should notify the Faculty office in writing.

## JOINT COMMISSION WORKSHOP

A jointly sponsored workshop on the new accreditation regulations of the Joint Commission on Accreditation of Hospitals has been set for February 3 and 4, 1972 in Baltimore.

The exact location and agenda for this session, being developed by the Faculty and the Hospital Association, is still to be announced.

## STATE DRUG REGISTRATION

The Executive Committee of the Faculty has determined it to be appropriate for physicians to comply with a new state law effective July 1, 1971, requiring physicians to register with the Division of Drug Control, Department of Health and Mental Hygiene.

If you have not already done so, you are urged to complete the appropriate registration forms promptly. Copies can be obtained from the Division of Drug Control, Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore, Maryland 21201, Telephone: 383-2729.



JOINING  
JCAH

Arthur G. Siwinski, MD, will join the Joint Commission on Accreditation of Hospitals as a part-time inspector commencing January 1, 1972. He will close his office, where he has practiced surgery for many years, just prior to that date.

In his new position, Dr. Siwinski will be part of the various inspection teams that ensure hospitals are carrying out their responsibilities under accreditation rules. His training program begins at the time he assumes his new duties.

FREDERICK  
PLANNING  
APPOINTMENTS

The County of Frederick has named a Regional Health Planning Council. Included among its members are Robert J. Thomas, MD, Chairman; Charles Spicknall, MD, County Health Officer; The Hospital Administrator, Wallace Dow; and the Dental Society President.

1972  
GENERAL  
ASSEMBLY

The 1972 General Assembly goes into session on Wednesday, January 12, 1972. Components are, in the meantime, scheduling meetings with their legislative delegations and individual legislators.

The first issue of The Assemblyman will be published early in the new year, when details on legislative proposals known at that time will be provided to all members.

NEW HEAD  
OF  
FAMILY PRACTICE

Newly named head of the Family Practice Department at the University of Maryland School of Medicine is Edward J. Kowalewski, MD, former president of the American Academy of General Practice.

Incidentally, the former Maryland Academy of General Practice is now the Maryland Academy of Family Practice.



John Sargent

Executive Director



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# Medical News Briefs

## Medicare Changes Noted

Beginning in January, an older person who goes to the hospital under Medicare will be responsible for the first \$68 (now \$60) of his hospital bill—now running about \$800 for the average stay by a Medicare beneficiary.

HEW officials attribute this increase to increased hospital costs and intend it to make the Medicare beneficiary responsible for expenses equivalent to the average cost of one day of hospital care.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay \$17 a day for the 61st through the 90th day, up from the present \$15 per day. If he has a post-hospital stay of over 20 days in an extended care facility, he will pay \$8.50 per day toward the cost of the 21st day through the 100th day, up from the present \$7.50 per day.

If he needs to draw on his "lifetime reserve," the reserve of hospital days a beneficiary can draw upon if he ever needs more than 90 days of hospital care in the same benefit period, he will pay \$34 for each day used instead of the present \$30 per day.

## Psychiatric Prize Award

The Maryland Association of Private Practicing Psychiatrists and the Maryland Psychiatric Society announce a contest to grant an award to the author of a psychiatric paper. The winner will read his paper at a joint meeting of the two societies on March 9. Manuscripts must be received

by January 15. Mail to William H. Arnold, MD, 827 Park Ave., Baltimore, Md. 21201.



**MALE NURSE**—Pictured receiving his diploma from South Baltimore General Hospital President Board of Trustees Harry B. Cummings is Steven Gelumbauskas. The first (and only) male student to attend their school of Practical Nursing, Steve graduated with 21 classmates. Since the school started in 1951, 313 students have graduated.

## Essay Entries Urged

An award has been offered to the medical student, intern, or resident under 30 who authors the best manuscript on "Man and His Moods." The winner will receive \$250 and travel expenses to attend and present the essay at the Fourth Annual Taylor Manor Hospital Psychiatric Symposium in Ellicott City, Maryland on April 15.

The theme of the symposium is "Man and His Moods." The biochemical and physiological bases for normal and abnormal moods and the clinical manifestations of mood changes will be explored by a group of nationally known leaders in the field of psychiatry.

An original and one copy of the double-spaced typed manuscript (3,000 words) should be submitted by January 10 to Frank J. Ayd, Jr., MD, symposium director, 912 West Lake Ave., Baltimore, Md. 21210. Contact him for further details.

## 100 Years Ago

This might have been included in the "Did You Know" column. Gleaned from the files of *The Sunday Sun* and included in their "This Was Baltimore 100 Years Ago" magazine section of their October 31st issue was the following:

"October 27—An Old Medical Society—The Medical and Chirurgical Faculty of Maryland, which holds its next semiannual convention in Annapolis, is the oldest medical society in the United States. It was chartered in the year 1798. Its first meeting was held in Annapolis on the first Monday in June, 1799."

Editor's Note: And they have been meeting ever since!

## Art Association Memberships

The American Physicians Art Association, 3801 Miranda Ave., Palo Alto, Calif. 94304, invites their medical colleagues to become members of their national nonprofit organization which is dedicated to furthering art interests in the medical profession.

An art exhibit is held in conjunction with the annual AMA meeting. You do not necessarily have to be currently engaged in any art activity to become a member. For further information, contact their president, A. M. Gottlieb, MD, at the above address.



## Public Education Program Launched To Recruit Voluntary Blood Donors

The American Association of Blood Banks (AABB) has launched a massive nationwide public education program to recruit more voluntary blood donors. A major purpose of the effort is to eliminate the high risks of hepatitis or other infections associated with the use of blood obtained from paid donors. The new program was announced by William G. Battaile, MD, AABB President.

"So much has been written about the bad practices associated with paying donors that the public has a distorted picture of blood banking in the United States," said Dr. Battaile. "We must convince people that only they can eradicate bad practices and paid donors through volunteering to give blood. We want to eradicate the paid donor as quickly as possible. Paying for blood not only increases the chance of transmitting hepatitis through transfusions, but it also discourages voluntary donations." Dr. Battaile stated that blood is living, human tissue, and blood transfusions in that respect were the first human tissue transplants. "If we continue to allow for the payment for blood," he said, "we will eventually have to put price tags on hearts, kidneys, and lungs, and permit human bodies to be bartered to the highest bidder."

The new public information program will utilize communications media and public information tools on a national, state, and local basis to increase voluntary blood donations for the benefit of all blood banks. Donors will be urged to give to the nonprofit blood collection facility most

convenient to them; ie, hospital, community blood bank, or Red Cross Center.

"Currently only about 3% of the 100 million medically fit adults in the U.S. voluntarily give blood each year," Dr. Battaile stated. "The nation's blood needs have been rising about 12% a year, and blood banks need 7 million pints this year. We believe that this vital health need for our people can be met on an all-volunteer basis if we achieve proper coordination, motivation, and communication with the public," he said.

There are two major non-profit blood banking organizations in the United States—the AABB with its more than 1,500 hospital and community blood bank members, and the American Red Cross which, among its other activities, operates 59 regional blood centers. The two organizations, through their members and centers, each supply about half of the blood used in the United States that isn't purchased from commercial blood banks. The AABB has invited the American Red Cross to participate in the new public education program as a joint effort of the AABB and the Red Cross. Both groups have been working cooperatively since 1960 under an interorganizational agreement for the exchange of blood and blood replacement credits between AABB banks and ARC centers.

The AABB also will call on government and national organizations to help implement an effective program of *public education* to arouse and recruit volunteer blood donors on a nationwide basis.



PROCLAMATION—Mrs. Roger Windsor, of Med-Chi's Woman's Auxiliary, was pictured with Maryland's Governor, Marvin Mandel, with the Governor's proclamation of the week of October 17-23 as Community Health Week.

## MD Office Labs Review Offered

Two national medical specialty societies have joined to offer a proficiency testing program to physicians with office laboratories.

The American Society of Internal Medicine and the College of American Pathologists have designed PEP (Proficiency Evaluation Program) for monitoring the capabilities of the physician's office laboratory and for conducting an economical, comprehensive evaluation of his own test results.

Participation in the proficiency testing program is entirely confidential. The physician receives data which compares the performance of his laboratory to a peer group comprised of all participating physician office laboratories.

Physician-subscribers are sent test materials and instructions quarterly. The test results then go to an impartial computer processing center. Results are matched and compared to those obtained for the same tests by reference laboratories and other physicians' office laboratories. Finally, a confidential report is returned to the physician.





NEIL SOLOMON, MD, PhD, SECRETARY

## Maryland State department of health and mental hygiene

### Cholera Shots Urged

Persons intending to travel to countries where cholera is present are being urged to get cholera vaccine before leaving the United States, in order to avoid delays and what some travelers have called "official red-tape," according to Howard Garber, MD, Chief of the Division of Communicable Diseases for the Maryland Department of Health and Mental Hygiene.

"In addition," Dr. Garber warned, "there have been instances where Americans abroad have been vaccinated for cholera, with several persons being given the vaccine with the same needle, a practice not acceptable by American standards."

At the present time only Spain and Portugal in Europe are reporting cholera, but travelers should check with their local health officer to be certain about current medical advice concerning the countries they intend to visit.

### Early Abortion Decision Urged

The necessity for early decision by persons who may be seeking abortion was stressed by Matthew Tayback, MD, Maryland Assistant Secretary of Health and Mental Hygiene, as he revealed that the department is helping more than 2,000 women each year with abortion counseling and medical services. And he expects the number to increase.

"It is an essential service we perform," he said, "in assisting mothers and future participants in planned parenthood to make responsible decisions."

In an analysis of cases, Dr. Tayback explained, a significant fraction involves abortions from 16 to 20 weeks in gestation. He expressed a deep concern over these cases because they involve more risk of complications, more emotional upset on the mother and professional staff performing the operation, and a

much greater expense of manpower and in post-operative care.

Dr. Tayback advises women who for legally satisfactory reasons . . . severe emotional stress, potential serious physical complications, rape, or probability of birth defects . . . cannot continue with pregnancy, to make the decision early, that is before the tenth week, and then seek medical advice.

Abortions performed before the twelfth week constitute a relatively simple medical procedure, with a minimum to zero risk-factor, and at very modest cost. "As a matter of fact," the assistant secretary said, "early abortions are usually sufficiently simple as to allow the woman to be admitted in the morning and be discharged late in the afternoon of the same day."



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# **your medical faculty at work**

**by John Sargeant  
Executive Director**

The Executive Committee met on Thursday, November 11, 1971, and took the following actions:

1. Tabled a reconsideration request for payment of postage expenses in connection with a proposed survey on professional liability insurance to be sponsored jointly by CNA and the Faculty.
2. Authorized for inclusion in the 1972 budget sufficient funds to pay the expenses of the two alternate delegates and the Faculty president to attend official meetings of the AMA House of Delegates. This will be in addition to payment of expenses of the three delegates and the senior alternate delegate.
3. Declined to approve a regular yearly contribution to MMPAC for educational activities.
4. Agreed not to pursue further the question of constitutionality of the state law, effective July 1, 1971, requiring registration by all physicians who prescribe drugs.
5. Authorized the treasurer and executive director to make appropriate arrangement for repair or replacement of the main compressor unit in the building's air conditioning system.
6. Approved submission of the following list of names of physical therapists for appointment to fill an unexpired term through 1974:

Rodney Schlegel, Laurel

Mrs. Florence Kendall, Baltimore

Miss Kathleen Dixon, Baltimore

7. Authorized submission of the following name for appointment to the Medical Advisory Board, Department of Motor Vehicles:

John W. Eckholdt, MD, Baltimore, Neurologist

The Executive Committees of the Maryland Hospital Association and the Medical and Chirurgical Faculty met jointly on Thursday, November 11, 1971, at the Faculty building to discuss mutual problems.

Discussed at this time, although no specific actions or definitive motions were made, were:

1. State legislative activity for the 1972 General Assembly session.
2. Utilization Review and the problems that might arise unless joint efforts are made in the areas of education. Blue Cross and Blue Shield both advise that considerable concern is being expressed by payors of large accounts regarding the rising costs of health care. Joint expression was made that both groups would cooperate with the Blues to explore any mechanisms that could assist them in their administration of these programs.
3. Discussed mechanisms so that both groups could be informed when disciplinary actions are taken against physicians.



# Doctors take note...

## Maryland Meetings

- |          |     |   |
|----------|-----|---|
| February | 3-4 | Joint Commission on Accreditation of Hospitals, Accreditation Workshop, Baltimore. Sponsors: Maryland Hospital Association, Maryland Hospital & Education & Research Foundation, and Med-Chi.   |
| February | 6   | 12th Annual Scientific Session, Maryland Thoracic Society, Sheraton-Baltimore Inn. Contact: Md. TB & Respiratory Disease Assoc., 11 E. Mt. Royal Ave., Baltimore, Md. 21202.  |
| February | 7-8 | 12th Annual Scientific Session, Maryland Thoracic Society, Sheraton-Baltimore Inn. Contact: Md. TB & Respiratory Disease Assoc., 11 E. Mt. Royal Ave., Program. Contact: Dept. of Rehab. Medicine, Sinai Hospital, Belvedere Ave. at Greenspring, Baltimore, Md. 21215. |

## American College of Physicians

- |          |       |  |
|----------|-------|--|
| February | 1-3   | Understanding & Managing Eczematous Diseases, Univ. of Oregon Med. School, Portland.   |
| February | 7-9   | Gastroenterology—Digestion & Disorders of Digestion. Div. of Gastroenterology & Mayo Graduate School, Rochester, Minn.   |
| February | 23-25 | Diagnosis & Management of Infectious Diseases. Univ. of California, Center of Health & Science, Los Angeles. For information on these ACP postgraduate courses, contact Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104. |

## American College of Obstetricians & Gynecologists

- |         |       |   |
|---------|-------|---|
| January | 6-9   | The Mother & Newborn—Recent Advances, 9th Annual Postgraduate Seminar. Miami Beach, Fla. Contact: Postgraduate Seminar in Anesthesiology, Dept. of Anesthesiology, Univ. of Miami School of Medicine & Jackson Memorial Hosp., Miami, Fla. 33136. |
| January | 20-21 | Tucson Seminar in Obstetrics & Gynecology. Contact: C. C. Christian, MD, Dept. of Obstetrics & Gynecology, Arizona Med. Center, Tucson, Ariz. 85724.  |

## American College of Physicians

- |         |       |   |
|---------|-------|---|
| January | 19-21 | Intensive Respiratory Care for Nurses, Inhalation & Physical Therapists. Salt Lake City. Sponsors: ACP, Intermountain (Utah) Regional Med. Program, American Assoc. for Inhalation Therapy. |
| January | 27-29 | Respiratory Function & Therapy, Los Angeles. Sponsors. ACP, Hosp. of the Good Samaritan Med. Center.  |

## American Academy of Facial Plastic & Reconstructive Surgery

- |         |       |  |
|---------|-------|--|
| January | 23-29 | Concepts of Soft Tissue Surgery, Mercy Hosp., Pittsburgh. Sponsors: AAFP&RS. Contact: John T. Dickinson, MD, G-2 MD Bldg., 1501 Locust St., Pittsburgh, Pa. 15219. |
|---------|-------|--|

## Miscellaneous Meetings

- |         |       |  |
|---------|-------|--|
| January | 17-18 | Seminar on Evaluation of Instructional Media in Medical Education. Atlanta. For faculty members in schools of medicine & allied sciences & directors of medical education. Contact: National Medical Audiovisual Center, Educ. Research & Training Branch, Atlanta, Ga. 30333. |
|---------|-------|--|



# Medical and Chirurgical Faculty Automobile Lease Plan

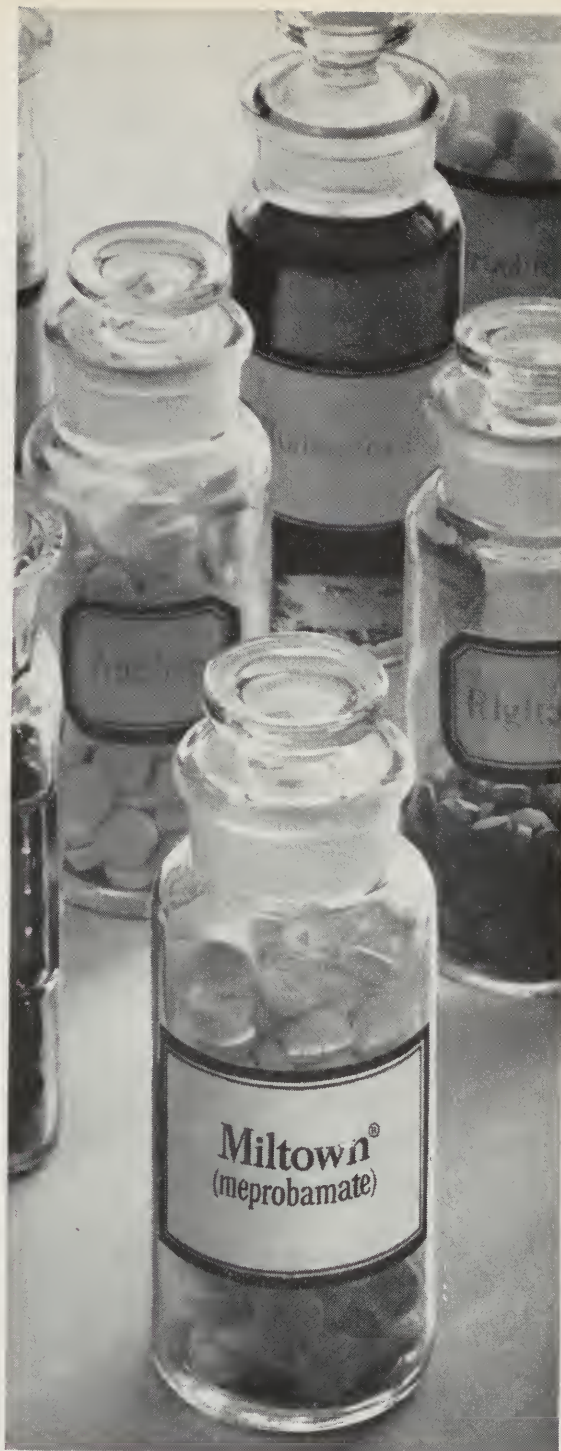


*Order Your New '72 Now.*

*An exclusive leasing program  
for members of the  
Medical and Chirurgical Faculty  
of the State of Maryland*

**Call 301/323-9440**

*Medical furnishings & equipment  
leasing also available.*



**Still serving...**

**Miltown®**  
(meprobamate)

WALLACE PHARMACEUTICALS   
Cranbury, N.J. 08512







MARK THESE DATES ON YOUR 1972 CALENDAR TODAY

WEDNESDAY, THURSDAY, FRIDAY

MAY 3, 4, 5, 1972

BALTIMORE CIVIC CENTER

174th ANNUAL MEETING

OF THE

MEDICAL AND CHIRURGICAL FACULTY

SCIENTIFIC PROGRAM TO STRESS  
CONTINUING MEDICAL EDUCATION FOR ALL PHYSICIANS

- **PEER REVIEW**, the plenary session topic, features OTTO C. PAGE, MD, President of the American Society of Internal Medicine. Peer review chairmen will discuss pitfalls, caveats, procedures, and safeguards.

- **SPECIALTY PROGRAMS WILL COVER:**

PEDIATRICS	CARDIOLOGY	RHEUMATIC DISEASES
OBSTETRICS AND GYNECOLOGY		THORACIC SURGERY
ANESTHESIOLOGY	PSYCHIATRY	INDUSTRIAL MEDICINE
CLINICAL PHARMACY		REHABILITATION MEDICINE
INTERNAL MEDICINE	OPHTHALMOLOGY	TRAUMA
RADIOLOGY		OTOLARYNGOLOGY
	MEDICOLEGAL PROBLEMS	

- **SPECIALTY PROGRAM SPEAKERS INCLUDE:**

C. HENRY KEMPE, MD, Professor and Chairman of the Department of Pediatrics, University of Colorado Medical Center

JOHN L. DECKER, MD, Chief of Arthritis and Rheumatism, National Institute of Arthritis and Metabolic Diseases

LOUIS M. HELLMAN, MD, Professor of Obstetrics and Gynecology, New York Downstate Medical Center

W. GERALD AUSTEN, MD, Professor of Surgery, Harvard Medical School

CHARLES J. FRANKEL, MD, Associate Professor of Orthopedics, University of Virginia

- **OTHER ACTIVITIES scheduled for the Annual Meeting:**

ROUND TABLE LUNCHEON	HEALTH EVALUATION TESTS
PRESIDENTIAL RECEPTION AND BANQUET	
SCIENTIFIC EXHIBITS	TECHNICAL EXHIBITS
ART AND HOBBY EXHIBIT	

- Applications for Scientific Exhibits and the Art and Hobby Exhibit appear elsewhere in this issue of the JOURNAL.

WATCH THE MARYLAND STATE MEDICAL JOURNAL FOR FURTHER DETAILS

IMPORTANT DATES—MAY 3, 4, 5, 1972

John B. De Hoff, MD, Chairman  
Committee on Program and Arrangements



# she has a plan that works





She has a plan that works.  
She has one plan for the  
class. And they really respond.

She has another plan just  
for herself. A medication plan  
for her hypertension. And she's  
also responding beautifully.

More than just another  
antihypertensive, Ser-Ap-Es  
can be a whole medication plan  
for living with hypertension.

Does it get good marks for  
comfort?

Excellent. Because  
Ser-Ap-Es controls blood pres-  
sure effectively, dosage of each  
component is lower than if pre-  
scribed alone, usually minimiz-  
ing side effects. However, side  
effects may occur (see prescrib-  
ing information).

Designed with the kidney  
in mind?

Hydralazine maintains  
or increases renal blood flow.

And the brain too?

Hydralazine also relaxes  
cerebral vascular tone. And  
reserpine has beneficial calm-  
ing action.

Is strict dietary discipline  
necessary?

Hydrochlorothiazide  
eliminates excess salt and  
water. So dietary salt restric-  
tions can be relaxed a bit.

Practical on a teacher's  
salary?

Ser-Ap-Es means single-  
prescription economy.

Will she do her  
"homework"?

More than likely.  
Ser-Ap-Es offers all the anti-  
hypertensive medication  
many patients need in a single  
tablet. It's easier. Encourages  
cooperation.

Ser-Ap-Es supplies many  
kinds of benefits...

Only Ser-Ap-Es adds  
Apresoline® (hydralazine) to  
rauwolfia-thiazide.

Please turn page for brief  
prescribing information.

C I B A

# Ser-Ap-Es<sup>®</sup>

reserpine 0.1 mg  
hydralazine hydrochloride 25 mg  
hydrochlorothiazide 15 mg

## a plan for living with hypertension



# Ser-Ap-Es®

reserpine  
hydralazine hydrochloride  
hydrochlorothiazide

0.1 mg  
25 mg  
15 mg

**INDICATIONS:** All cases of hypertension except the mildest and the most severe.

## CONTRAINDICATIONS

**Reserpine:** Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

**Hydralazine:** Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

**Hydrochlorothiazide:** Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

## WARNINGS

**Reserpine:** Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

**Hydralazine:** Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

**Hydrochlorothiazide:** Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

## Use in Pregnancy

**Reserpine:** The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

**Hydralazine:** Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the

idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient. **Hydrochlorothiazide:** Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

## PRECAUTIONS

**Reserpine:** Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

**Hydralazine:** Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

**Hydrochlorothiazide:** Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

## ADVERSE REACTIONS

**Reserpine:** Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when

used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

**Hydralazine: Common:** Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

**Less frequent:** Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly. **Hydrochlorothiazide:** Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

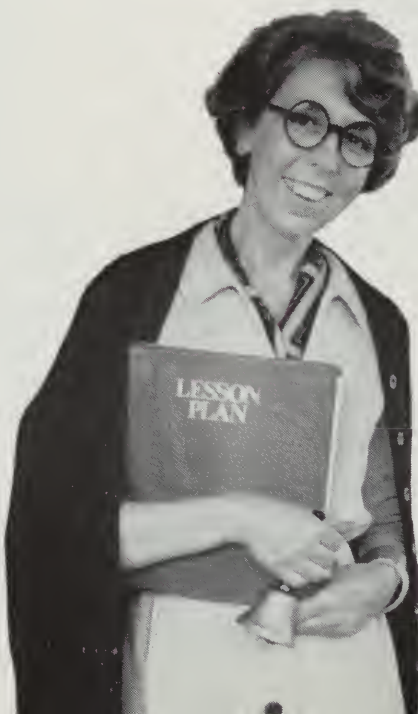
**DOSAGE:** One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

**SUPPLIED:** Tablets (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company  
Summit, New Jersey

2/4524



she has a plan  
that works  
for living with  
hypertension

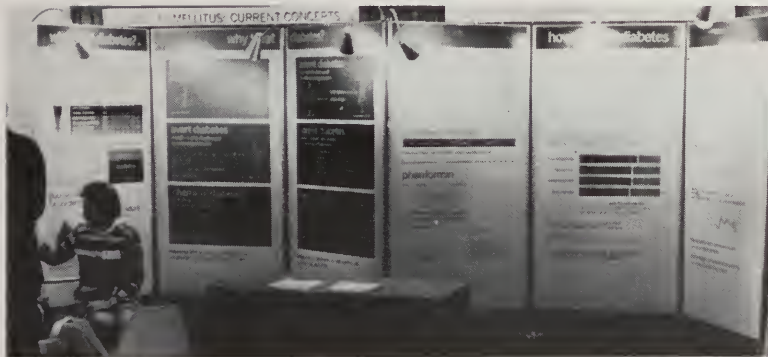
# Ser-Ap-Es®

reserpine 0.1 mg  
hydralazine hydrochloride 25 mg  
hydrochlorothiazide 15 mg

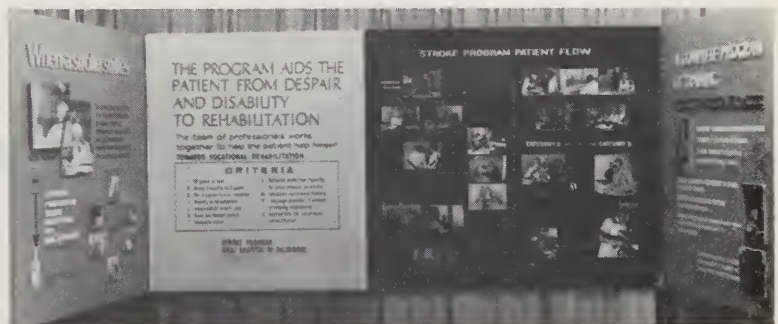
# C I B A



# 1971 SCIENTIFIC EXHIBIT WINNERS



DIABETES MELLITUS: CURRENT CONCEPTS



VOCATIONAL REHABILITATION OF STROKE PATIENTS

EXHIBIT WINNERS—Judges for the exhibits at the annual meeting of the Medical and Chirurgical Faculty were hard pressed to select the top exhibit. So they settled on two as being the most outstanding: Diabetes Mellitus — Current Concepts, and The Vocational Rehabilitation of the Stroke Patient. The “Biology of the Sea Nettle” exhibit was judged the most unusual. The Exhibit Subcommittee invites exhibitors to make application for scientific exhibit space for the 1972 Annual Meeting to be held at the Civic Center in Baltimore on May 3 through 5. See the rules governing scientific exhibits form elsewhere in this Journal.



BIOLOGY OF THE SEA NETTLE



An epidemic that's striking home...

# gonorrhea

There were over 14,000 reported cases of gonorrhea in the Old Line State last year... 75 percent of them in Baltimore alone

In Maryland...and everywhere else...  
a new alternative

**NEW Trobicin<sup>®</sup>** SPECTINOMYCIN  
DIHYDROCHLORIDE, PENTAHYDRATE, UPJOHN

**single-dose treatment for  
intramuscular use only**

a chemically distinct antibiotic indicated specifically  
for treatment of acute gonorrhea:

in the male—acute urethritis and proctitis

in the female—acute cervicitis and proctitis

when due to susceptible strains of *N. gonorrhoeae*

**High cure rate:**\* 96% of 571 males, 95% of 294 females  
(Dosages, sites of infection, and criteria for diagnosis  
and cure are defined on page 3 of advertisement).

---

**Assurance of a single-dose, physician-controlled  
treatment schedule**

---

**No allergic reactions occurred in patients with  
an alleged history of penicillin sensitivity  
when treated with Trobicin, although penicillin  
antibody studies were not performed**

---

**Active against most strains of  
*Neisseria gonorrhoeae in vitro* (M.I.C. 7.5-20 mcg/ml)**

---

**A single two-gram injection produces peak serum  
concentrations averaging about 100 mcg/ml in  
one hour** (average serum concentrations of 15 mcg/ml  
present 8 hours after dosing).

---





NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated for the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.



# Trobicin and the gonorrhea challenge

## An accelerating epidemic— a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection—and it should not demonstrate cross-resistance with penicillin

## Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

### High cure rates:

**96% of 571 males, 95% of 294 females**

**No allergic reactions occurred in patients with an alleged history of penicillin hypersensitivity when treated with Trobicin, although penicillin antibody studies were not performed.**

## Chemically distinct

Trobicin is structurally not related to any other antibiotic commonly used to treat gonorrhea.

## The assurance of a single-dose, physician-controlled treatment schedule

Intramuscular injections should be made deep into the upper outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrheal urethritis. Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in gonorrheal proctitis and in patients being re-treated after failure of previous antibiotic therapy. In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams intramuscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in acute gonorrheal cervicitis and proctitis.

Safety for use in pregnancy has not been established, nor has safety for use in infants and children.

Clinical Results with Single-Dose Treatment, Intramuscularly\* (Data compiled from reports of 14 investigators\*\*)

	Dosage	Number of Patients	Number Cured	Percent Cured
<b>Adult Males:</b> Gonorrheal urethritis	<b>2 grams</b>	<b>475</b>	<b>457</b>	<b>96%</b>
	<b>4 grams</b>	<b>96</b>	<b>93</b>	<b>97%</b>
<b>Adult Females:</b> Gonorrheal cervicitis	<b>4 grams</b>	<b>294</b>	<b>280</b>	<b>95%</b>

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluable and were not included in the table above.

The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

\*4-gram doses were injected in two gluteal sites.

\*\*Medical Research Files, The Upjohn Company



a chemically distinct antibiotic indicated  
specifically for treatment of  
acute gonorrheal urethritis and proctitis in males  
and cervicitis and proctitis in females  
when due to susceptible strains of *N. gonorrhoeae*

# new **Trobicin®**

STERILE SPECTINOMYCIN DIHYDROCHLORIDE  
PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

## **sterile Trobicin®**

spectinomycin dihydrochloride pentahydrate)—For Intramuscular injection: 4 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

an aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between trobicin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

**Warnings:** Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 6 months should be instituted if the diagnosis of syphilis is suspected.

**Safety for use in infants, children and pregnant women has not been established.**

**Precautions:** The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

**Adverse reactions:** The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25°C and use within 24 hours after reconstitution with diluent.

**Male**—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic re-

sistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

**Female**—single 4 gram dose (10 ml) intramuscularly.

**How supplied:** Vials, 2 and 4 grams —with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

**Susceptibility Powder**—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

**Human pharmacology:** Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert.

MED-B-1-S (LWB)

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001





MRS. WALLACE H. SADOWSKY, EDITOR

woman's auxiliary

## SEMIANNUAL MEETING REPORT



*(Mrs. Edmund V. Niklewski, delegate from the Washington County Medical Auxiliary, prepared the following report on her enjoyable trip.)*

At 8:30 AM on September 15, 1971, some 340 Med-Chi members and their families boarded the giant Eastern Air Lines 747 jumbo jet at Baltimore's Friendship Airport to embark on what was to be one of the most interesting, well-planned, and fun-filled semiannual meetings ever. After a delicious breakfast, served with champagne and complimentary cocktails, and a visit by most of the passengers to the upstairs lounge, we arrived in San Juan, Puerto Rico about 1:00 PM to find sunny 90-degree weather. From there we were taken by air-conditioned buses and limousines 35 miles to the El Conquistador, a luxury hotel high on a cliff overlooking the Caribbean Sea in one direction and the Atlantic Ocean in another.

As we approached the hotel, we could see its immense golf course stretching from the road in every direction, and yet were only able to see part of the hotel, since it is built on levels on the side of a cliff. Two funiculars and a cable car carry guests to the two pools and marina at the foot of the cliff. There is still another pool located at street level, apparently for those who hesitate to take the exciting ride over the cliff to the bottom.

**GOVERNOR'S LUNCHEON**—Governor H. Melvin Evans of the Virgin Islands spoke at the luncheon meeting of the Med-Chi semiannual meeting in Puerto Rico. From the left, those seated at the head table are: Mrs. Chad Combs, Robert A. Reiter (MD), Mrs. John B. De Hoff, Governor Evans, Mrs. Robert A. Reiter, John B. De Hoff (MD), Mrs. H. Melvin Evans, and Chad Combs.

Every detail of this trip was apparently well-planned in advance, for our luggage arrived at our rooms, as promised, within a short time after our arrival, and the hotel had reservation packets already prepared for each guest. The lack of confusion and delay during the trip was one of its most enjoyable aspects, considering the large number of people arriving and departing at one time.

After a festive rum swizzle party with fancy hors d'oeuvres, everyone had dinner in the huge main dining room of the hotel. Many then followed this with a visit to the extremely modern casino, where many doctors and their wives watched money come and go. One of the popular pastimes of those of us unable to meet the one dollar or five dollar minimum bets was watching the "regulars," who bet as high as \$200 at a time. (We all concluded they must not have to earn their money as doctors do.)



Near the casino was the hotel discotheque, SUGAR'S, which could be entered only by walking along a glass runway bordered by pools of water. There, in unusual surroundings, including a Volkswagen car, people could enjoy themselves until the wee hours of the morning.

My husband and I had an interesting experience the first night when we decided to take a ride on the funicular to see the view at night. We inadvertently joined a small group that included the wife of the governor of Nevada and her escorts. The Governors' Conference had ended that day in San Juan, and she was being given a private tour of the El Conquistador. We were invited to join their group and received a tour of the grounds and a look at the Hydrofoil boat. This boat, which can carry over 100 people, rises up on rudders to skim the water and make the 70-mile trip from the hotel to the Virgin Islands in less than two hours. Many in our group made this trip on the Hydrofoil to take advantage of a day of shopping in a duty-free port in the Virgin Islands.

The next day, Thursday, after a bountiful buffet breakfast, Mrs. Robert Reiter called to order the meetings of the Woman's Auxiliary while the physicians began their meetings with the Puerto Rican Medical Association. Doctor Alden brought greetings to the auxiliary from the Medical and Chirurgical Faculty and urged the auxiliary to help the doctors in the passage of medical legislation in Annapolis. The political wallop that women carry, he said, could give Med-Chi the added push it needs. He asked the Auxiliary Legislative Committee to keep in touch with Jack Sargeant's office and to give it their support. The response to Dr. Alden was made by Mrs. Robinson of Easton.

The auxiliary pledge, led by Mrs. Miles, was followed by the roll call of delegates. The following nominating committee was then elected:

Mrs. Raymond Yow, Wicomico County —  
Chairman

Mrs. Gordon Smith, Montgomery County

Mrs. W. G. Speicher, Carroll County

Mrs. William Gunther, Prince George's  
County

Mrs. Arthur Bauer, Allegany County

Mrs. Sullivan announced that the state award for AMA-ERF went to Montgomery County for contributing the largest amount, \$2,074.97. Montgomery County was also recognized at the national meeting in Atlantic City for having given the largest amount in its membership category. Mrs. Reiter announced that the next annual

meeting will be May 3 and 4, 1972, at the Hilton Hotel in Baltimore. The meeting was adjourned in time for auxiliary members to join their husbands for an address by H. Melvin Evans, MD, Governor of the Virgin Islands, the first physician-governor in the United States in 105 years.

Governor Evans, who was introduced by Dr. McKendree Boyer, was born in St. Croix, Virgin Islands, received his MD from Howard University and Master in Public Health from the University of California. In November 1970 he became the first elected governor. He spoke as one physician to another about the importance of their becoming involved in civic affairs. Most physicians, he said, have a valuable perspective on many problems.

Following his address, Governor Evans and his wife joined auxiliary members, their husbands, and guests from the Puerto Rican Medical Association at a luncheon arranged by the auxiliary. Mrs. Reiter welcomed all and urged everyone to attend the interesting meetings planned for the days to come.

Each day, in addition to the medical meetings, we were free to take part in the numerous activities available at the hotel. Golf, tennis, and swimming were enjoyed, as well as horseback riding on the Pasofino horses of Puerto Rico. The well-organized tours to El Yunque (The Rainforest), Old and New San Juan, Luguillo Beach, and all-day shopping excursions by Hydrofoil or seaplane to the Virgin Islands were further attractions.

My husband and I, along with Dr. and Mrs. Alfonso Lazo, elected to share the rental of a car and explore the sights at our leisure. One of our most memorable impressions of Puerto Rico, ranking with our walk through the Rainforest, was our trip into Fajardo, a small town about 15 minutes from the hotel. There we walked the noisy, crowded streets, had a coke in a small soda fountain, and watched a funeral procession of over 100 people walk slowly and quietly through the streets of the town to the local church. In Fajardo, we even bought comic books for our children — *BATMAN* and *THE LONE RANGER* in Spanish!

There was also nightlife other than that at the hotel. One night after our delicious full-course dinner at the hotel, we joined a group to drive into San Juan for a revue at one of the large hotels. Everyone agreed that it was well worth the 35-mile drive there and back.

The climax of the meeting came on Saturday night when the dinner dance was held in the opulent Casals Hall. After a well-served, delight-



ful dinner including Baba-a rum for dessert, Dr. De Hoff and his committee presented golf and tennis awards. Then came the entertainment — a fitting climax to a grand and glorious meeting! Most memorable was Chief Voodoo from Trinidad, a fire swallower who also held everyone spellbound as he proceeded to crush glass and then walk on it, roll in it, and finally allow a man and woman from the audience to stand on him while he stretched out over the glass. Following Chief Voodoo came two sprightly limbo dancers who led members of our group in a limbo contest. About 20 to 25 people took part and a winner was chosen from both the men and the women. There was a round of applause for the Med-Chi staff and Dr. De Hoff for this wonderful meeting at the El Conquistador Hotel.

Sunday, sad to say, came the time to return to the world of reality. Departure went just as smoothly as arrival — buses and limousines to our waiting 747 jet and the same familiar stewardesses to Friendship Airport. Probably most would agree that retrieving the luggage at Friendship was the first time the impact of the size of our group — 340 — fully hit us. All in all, much credit should go to the ones responsible for the careful planning of this exciting semiannual meeting. It is one to be long remembered!



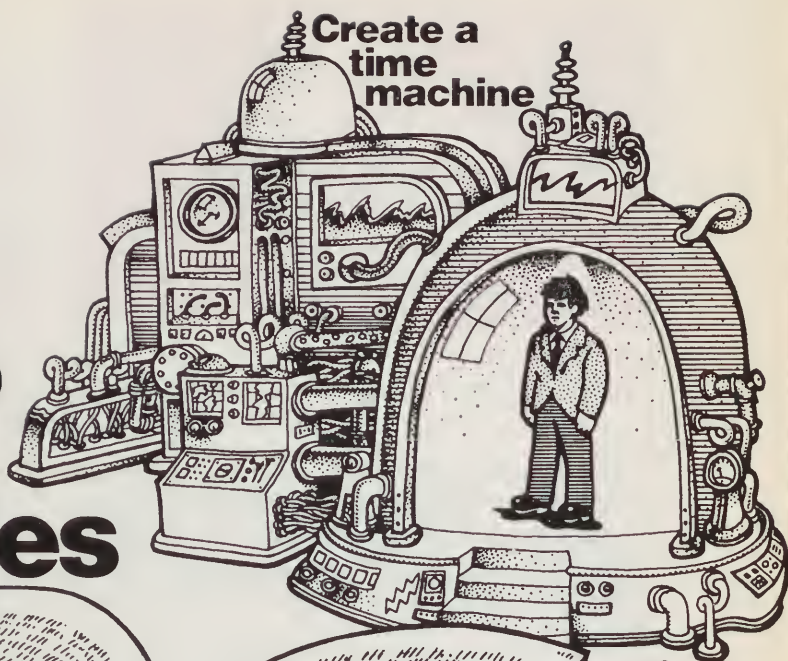
CHIEF VOODOO allowed Dr. Richard Y. Dalrymple and Mrs. Robert B. Goldstein to stand on him while he lay on a bed of crushed glass. A full stomach!

**LIMBO CONTEST**—More than 20 Med-Chi conventioners took part in a sprightly limbo dance contest. The winners shall remain anonymous by choice.





# What to do until suppositories work:



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Actually, on the average, evacuant suppositories take about an hour to work.<sup>1-3</sup> Sometimes two.<sup>4</sup> Sometimes more.<sup>3</sup> Also, suppositories can be ineffective in up to 38% of patients,<sup>5</sup> and not infrequently produce smarting, burning and tenesmus.<sup>6</sup>

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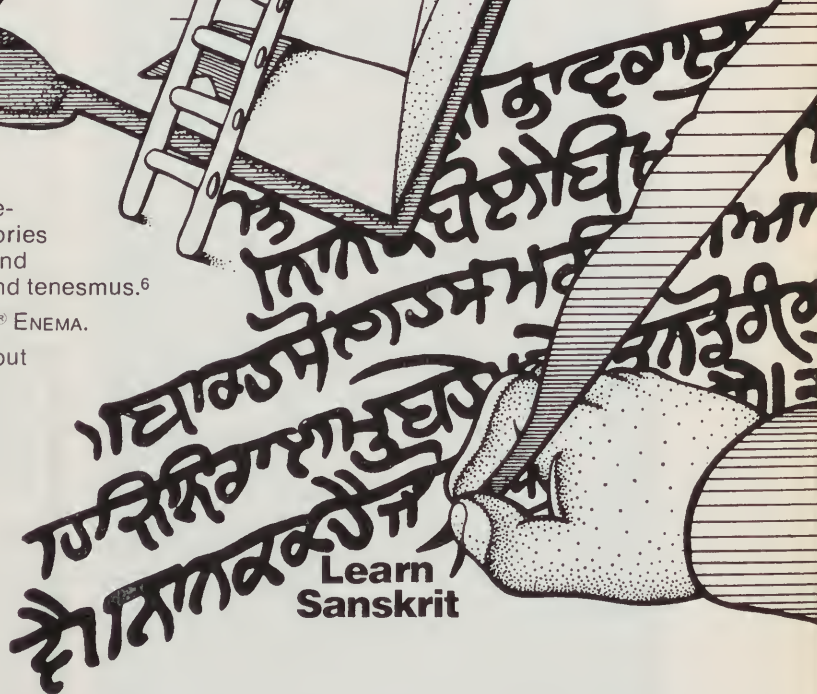
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**References:** 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsalt, P.: J Amer Geriatr Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.







ARTHUR E. COCCO, MD  
Journal Representative

## Baltimore City Medical Society

### Board of Directors Meets

The Board of Directors met for its regular meeting on October 12 and took the following actions:

Approved the recommendation of the Finance Committee that all funds now in savings accounts be held there for the time being. The proposed 1972 budget was also approved by the board and will be submitted to the membership at the annual meeting on December 2.

Requested the Bylaws Committee to consider an amendment which would increase the membership of the Professional Relations Committee from three to five members of the society, three of whom are to be selected from the Board of Directors and two from the general membership. The terms of service on the committee are to be staggered. This is a most important committee and it was felt that a larger membership would be able to handle some of the problems which are presented with more expertise.

Approved the request from the Medical Care Committee that a booklet describing the services rendered by the Instructive Visiting Nurses Association be included in a future mailing to the membership.

Agreed to request the AMA to conduct a public affairs survey for the society. It was the consensus that this survey which is conducted under the auspices of the AMA Department on Public Affairs which bears the cost, might provide some constructive information which would improve the function of the society.

Denied the request from a physician for dues-exempt status.

Approved a new format for the monthly publication of the society. The approved Policy and Planning recommendation which called for a revision in the monthly meeting notices which are published by the society. The revision will be in the form of a newsletter which will publish not only the monthly meetings but will include much of the mimeographed material now enclosed in monthly mailings.

Approved the following 1972 meeting dates:

#### General Meetings

(Thursdays, 8:30 PM)

January 6, February 3, March 2, April 6,  
October 5, November 2, December 7.

#### Board of Directors Meetings

(Tuesdays, 4:30 PM)

January 11, February 8, March 14, April 11,  
May 9, June 13, July 11, August 8, September 12,  
October 10, November 14, December 12.

Voted to contribute \$50 to the preceptorship fund of the Maryland Academy of General Practice. This fund is to be used to support preceptorships in general practice for students in the University of Maryland interested in the field of family practice medicine.

Endorsed and urged approval of Question Number 3 "Offstreet Parking for Hospitals," Ordinance No. 1100, which will be presented in the November election.

Declined an invitation from the Baltimore Gas & Electric Company to tour the nuclear plant at Calvert Cliffs. It was the consensus that the board as the administrative body of the society should not accept the invitation but that individual members of the board were free to participate if they so elected.

The meeting was adjourned at 6:00 PM.

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## Baltimore County Medical Association

Members of the Baltimore County Medical Association, their spouses, and friends enjoyed the annual crab feast held in September. The food was delicious and the hospitality superb.

The annual dinner dance was held at the Hunt Valley Inn on October 17. A large crowd enjoyed the beautiful surroundings of this new Baltimore County facility.

The November meeting was held at St. Joseph Hospital. The program was planned by John Krejci, MD, of the hospital, and Herbert Levickas, MD, association program chairman. Following an afternoon scientific session, members, their spouses, and members of the hospital staff were guests of the Woman's Auxiliary of the Baltimore County Medical Association at a social hour.

We thank the hospital for the invitation to hold our meeting there and Drs. Krejci and Levickas for the scientific program.

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ADDRESS OF GOVERNOR H. MELVIN EVANS, M.D.  
AT THE MED-CHI SEMIANNUAL MEETING  
AT EL CONQUISTADOR, PUERTO RICO

SEPTEMBER 16, 1971



To begin, I can best recount an incident which occurred about a year and a half ago when I visited Airlie Foundation, Virginia. I was introduced to the President of the Foundation as Governor Evans. He didn't know me; and he was a physician. We chatted for awhile, then something he said made me give him an answer and made him suspect that I might be a physician. So he said, "You are a physician." I said, "Yes." He said, "Well let's cut this so and so out, you know, and really talk." So I'm going to cut all the trimmings out and really talk to you as one physician to another.

I first got into this because of the trend of events. When I finished medical school and came back to the Virgin Islands to practice, the furthest thing from my mind was to enter politics. And until about two and a half years ago that was still absolutely true. In fact, I had a stock remark when anybody asked me if I would like to be Governor of the Virgin Islands. My remark was: "Yes, after I have seen a psychiatrist to find out what is wrong with me!" But the movement of events indicated that one cannot live in a community, be a part of that community, and yet draw sharp lines as to what activities one will participate in and what one will not, because in so doing you often lose the development of your full potential. This became increasingly apparent in the late sixties when one party had been in power in the Virgin Islands for so long that the usual signs which accompany such long tenure in office were becoming more and more apparent.

**GOVERNOR'S ADDRESS**—Governor H. Melvin Evans of the Virgin Islands was pictured as he addressed Med-Chi's 1971 Seminannual Meeting held in Puerto Rico in September. Doctors John B. De Hoff and M. McKendree Boyer were seated at his left. Governor Evans is the first physician-governor in 105 years. He spoke on issues facing physicians and their involvement in governmental affairs.

And so, when in the summer of 1969 my name was suggested to the President, I must confess it was with reluctance that I accepted or allowed it to be. Why? Because I had just gone into private practice, having been in government all my previous years up until two years before, and I was really enjoying the freedom of private practice together with the income. But it was necessary to make a decision. This was my home. I had spent all my life there except for the time when I was in training. It was necessary that I do what I thought I could do to take the helm. That is why I am in this particular position today. I spent a year and a half as an appointed Governor. The Congress had already passed a law authorizing the Virgin Islands to have its own election for the Governorship in November 1970 and, obviously, the job that needed to be done could not be completed in a year and a half, so I stood for election. I suppose the greatest thrill that I had was the recognition on the part of the community that perhaps my work had not been all in vain. I mention this because it is necessary to understand the depth of feeling which I may express later in regard to the



necessity of physicians becoming involved in the civic affairs of their community.

There was a time when physicians were probably the most respected of people. I think it was Robert Louis Stevenson who said that there are certain classes of men that rise above all others: the soldier, the sailor, the shepherd not infrequently, artists rarely, rarely still the clergyman, but the physician almost always as a rule. He is the flower of our civilization. That was some time ago.

I just wonder how many people would feel that way today about physicians. And yet those of us who are in this profession know that perhaps it is just as true or even truer today than it was then when spoken. There are, perhaps, many reasons for it. I don't think that we can blame the specialization of physicians today for their withdrawal into the cocoon of medicine and separating themselves from the life of the community. After all, it was over five centuries B.C. when Herodotus remarked that the art of medicine in Egypt was such that one physician learned and paid attention to one field — some, diseases of the eyes; some, diseases of the head; others, ailments of the bowels — just to quote him briefly. And so the specialization which has become so presently dominant within the last few decades cannot be the main reason.

Nor do I believe we can blame the volume of knowledge or the volume of material which it is necessary for physicians to accumulate. I am not sure I have the answer, but I do know this: It has been a very, very long time that physicians have been gradually paying more and more attention to what they call the science of medicine and less to the art of medicine and, in so doing, separating themselves little by little from the general appreciation of their constituents. Of course, this is not entirely true of all; unfortunately, it has been an increasing tendency.

Perhaps we can use this to explain why it is that in the Congress of the United States there is not a single physician among the 100 senators and there are only four among the 435 representatives; and of the four only three were elected this past term. Perhaps this is why the American Medical Association was so very surprised. Perhaps, dumfounded is a better term, when I, as a physician, was elected. I think they were concerned over the odds which I encountered. But a little research on their part seemed to establish the fact that I was the first physician-governor in 105 years in the United States.

I am not sure if those figures are accurate but at least those are the figures they bring out. And yet when one realizes the length of training to which physicians are exposed, it seems incredible that their active role of leadership should not have been any greater than it has been. We can go down to the level of the state legislatures in which we find some more state senators and representatives, but still not really the number that we should find. What this means is that over the years there has been a tendency of physicians to let everything aside from medicine pass by. This has had some very adverse effects. We have only to look at the ill thought and rather unfair treatment to which physicians have been exposed in the national economy. Think how difficult it is, for example, for a physician who has spent, if he is specialized, perhaps a total of 25 to 27 years in training not to be able to have a decent retirement plan because he is self employed. And yet almost every businessman is able, as soon as he enters business, or as soon as he joins a firm, to secure for himself a reasonably designed retirement security plan.

What is the reason for this? Well, you know there are about 300,000 physicians in our country of 200,000,000 people, and the physicians have not seen fit to exert the true influence which they should exert. Lawyers have fared somewhat better. This is perhaps indicative of the fact that in the eyes of the community the physician has become a scientist or a scientific technician. They are awed at the wonders of surgery just as they are awed at the ability of this nation to put men on the moon, but the feeling is much the same. These are scientific achievements and just as the astronauts have not shown striking success in running for political office they perhaps feel that physicians would do better to remain in the scientific laboratory. I think we should challenge that.

And what are some of the other adverse effects on us as a nation? There are so many things that physicians are better prepared to deal with than anyone else. Let us look at the mess we have made in this nation in our management of drug control. The drug abuse problem increases day by day while the country flounders around not seeming to know what to do. No later than yesterday one governor expressed surprise that we should be so concerned over the drug problem. "After all," he said, "we had an epidemic in 1897 and it burned itself out. Just give this one enough time. It will burn itself out." I rather doubt we would find any physician taking that point of view.



Just look at the problems we have had with nutrition. Today America with its affluence — although it might be the fattest nation — certainly is not the best nourished nation. With all our scientific know-how, just look at our health picture. We are still way down the line, perhaps twelfth or thirteenth, in such vital indices as our maternal mortality and infant mortality. While I know that there are many reasons which explain this, including the lack of homogeneity of our population, it still means that the people who lead us do not necessarily have the proper appreciation of the manner in which these things should be solved.

Look at the present furor over the protection of environment. We as physicians should take an active part in this because we know more about the effects of disturbance of the environment on the human body. Five years ago when I went to Berkeley to take my course in public health, the word "ecology" was a word which hardly anyone knew. Today it is bandied about by every six-year old. Every person, particularly those with less than desirable medical training, are taking the leadership.

Then let us look at perhaps the most serious indictment of all: our public health system where we as physicians have allowed the whole area of public health to become fragmented so that on the one hand you have mental disease taken out, on another hand you have water control taken out, on another hand you have air pollution taken out; and you keep getting down and down until today there isn't a public health physician or director who does not tear his hair out when he knows he can't get the things he needs in order to do a good job. And what is more, unless we take a very, very firm stand, it is going to get worse because today we are in the age of computers, and the age of cost efficiency studies. This is not a wild dream or a wild fear. It is true. There is a small but increasing fraction of our population that feels that human life should be thought of in terms of cost efficiency, so that illness in a 60-year-old man and illness in a 20-year-old man are not handled the same because the cost necessary to cure the 20-year old, in their way of thinking, would be more than offset by his productivity during the remaining 40 years of his productive life, while the 60-year-old man is near the end of his, and perhaps the money could be spent better elsewhere. These are real fears that may come to pass. If you don't think that the present accent on youth will do something to increase this, then I suggest that you do some studying — because it will.

And so we come to the conclusion that if we are to realize the potential that we ought to, if we are to really take our place in society, if we are to provide the leadership which we ought to and must; if we are to be, as Plato said of physicians: "The physician is really a ruler, he has the whole human body as his subject, and is not merely interested in making money." Bear in mind these words were said by Plato centuries ago. If we are to do these things, I suggest that each and every one of us become involved deeply in our civic affairs.

Some time ago a physician had some problem with his bathroom plumbing on a Sunday and called in a plumber. The plumber came in and spent an hour clearing it up and charged him \$300, whereupon the physician really hit the ceiling. "Why," said he, "I wouldn't think of charging any of my patients \$300, even on a Sunday!" Said the plumber, "I didn't either when I was practicing medicine!" I think you get the point.

And so I would say to you, as Matthew Arnold said when he spoke these words, I think, in all seriousness, in all sincerity, and with an appropriateness which is great even today:

The Physician of the Iron Age  
Goethe has done his pilgrimage.  
He took the suffering human race,  
He read each wound, each weakness clear—  
And struck his finger on the place  
And said—Thou ailest here, and here, and  
here.

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1. Demeulenaere, L.: *Action du R 1132 sur le transit gastro-intestinal*, *Acta gastroent. Belg.* 21:674-680 (Sept.-Oct.) 1958.

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should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

**Adverse Reactions:** Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting,

pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

**Overdosage:** The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

**Dosage:** The recommended average initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

#### Children:

3-6 mo.... ½ tsp.\* t.i.d. (3 mg.)  
 6-12 mo.... ½ tsp. q.i.d. (4 mg.)  
 1-2 yr.... ½ tsp. 5 times daily (5 mg.)  
 2-5 yr.... 1 tsp. t.i.d. (6 mg.)  
 5-8 yr.... 1 tsp. q.i.d. (8 mg.)  
 8-12 yr.... 1 tsp. 5 times daily (10 mg.)  
**Adults:**.... 2 tsp. 5 times daily (20 mg.)  
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\*Based on 4 cc. per teaspoonful.

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## **Baltimore City health department**

# First Maryland Health Care Corporation Funded Through OEO

The First Maryland Health Care Corporation, a Baltimore nonprofit organization affiliated with the City Health Department, has been funded with a \$98,880 planning grant from the U.S. Office of Economic Opportunity.

Incorporated early in the year, this new organization is now in the process of designing health maintenance organizations (HMOs) to offer prepaid family health care packages to potentially as many as 200,000 Baltimoreans in the northwest and west sections of the city. Over the next two years First Maryland anticipates an additional two to three million dollars in OEO funds to help pay for health services. When completely organized, this nonprofit health agency will coordinate a network of consumers, interested physicians, medical groups, hospitals, neighborhood health centers, and community health councils.

The First Maryland Health Care Corporation will be one of 11 model HMOs funded through OEO to carry President Nixon's national health strategy to inner city residents. Robert M. Vidaver, MD, former director of education in the Maryland State Department of Health and Mental Hygiene, is the agency's first president. Health maintenance organizations are a new direction in health care. HMOs under First Maryland would provide total health care services from neighborhood centers for a single monthly premium. Subscribers and their participating family members could have any number of doctors' visits, consultations, or days of general hospital care. Two HMOs are operating now in the First Maryland area: one is sponsored by the West Baltimore Community Corporation, the other by Provident Hospital.

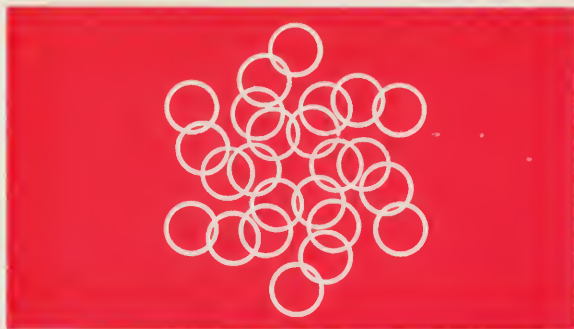
City Health Department studies indicate large numbers of Baltimoreans go without ordinary medical care simply because there are no physicians nearby. Fifteen of the city's census tracts are without a single primary care physician. Many more are woefully understaffed. In

search of solutions, John B. De Hoff, MD, Deputy Commissioner of Health, was assigned the job of implementing a pilot Baltimore HMO having particular concern for inner city people. First Maryland, which is patterned after the academic health manpower organization, the Maryland Consortium for the Health Sciences, grew out of this effort. Representatives of the Sinai, Provident, Lutheran and Bon Secours hospitals, the Provident OEO and West Baltimore neighborhood care centers, the Gar-Wyn Medical Group, the Baltimore City Medical Society, and the Northwest Community Organization have joined with City Health Department physicians James D. Carr, Jimmie L. Rhyne, and John B. De Hoff in the corporation. To be sure First Maryland's consumers get the services they need, its guiding Board of Trustees includes one half consumers, two thirds of whom are poor people.

The First Maryland Health Care Corporation, like other health maintenance organizations, seeks to develop group practice alternatives to the time-honored solo practitioner, fee-for-service medicine. Rising costs, doctor shortages, and crowded emergency rooms are adding impetus to HMO formation, the more so since Mr. Nixon's February "Health Message" endorsement.

While HMOs may take many forms, most of them gather a wide range of specialized medical services under a single administrative umbrella. The HMOs are to take responsibility for the patient's total health needs when he is well as when he is injured or ill. Doctors, nurses, and other allied health practitioners work as a team in the HMOs. HMOs work through facilities in hospitals, neighborhood centers, rehabilitation institutes, or private homes via community outreach. As neighborhood HMO satellites are developed they will make it easier for people to get medical care and will know where to turn before illness reaches crisis proportions.





From the Subcommittee on Alcoholism of the  
Medical and Chirurgical Faculty of the State  
of Maryland

## alcoholism section

# WOMEN'S ALCOHOLIC REHABILITATION UNIT UTILIZATION IN DEMOGRAPHIC DATA

March 1, 1970 - February 28, 1971

**GEORGE C. SJOLUND, MD**

Former Director

Alcoholic Rehabilitation Unit

Springfield State Hospital

On March 1, 1970, a 25-bed unit was established for the treatment of alcoholism for women at Springfield State Hospital in the Clark Circle 5-C area. During the first year of operation, data concerning the utilization of the unit and the demographic background of the patient population was gathered on each female patient admitted to Springfield with a primary or secondary diagnosis of alcoholism. Similar data was also gathered for the two months preceding the opening of the unit, that is from January 1, 1970 until February 28, 1970. This data furnishes a comparison on admission rates, as well as adding to the total patient population data.

From the period January 1, 1970 to February 28, 1971, 406 women were admitted to Springfield State Hospital with a diagnosis of alcoholism, according to the types listed in the diagnostic and statistical manual. The average length of stay at Springfield was 26.4 days. The total number of patients coming to the Women's Alcoholic Rehabilitation Unit (WARU) was 240. During the year that the unit was open, this was 60% of the number of alcoholic women admitted to Springfield State Hospital. The average length of stay in the WARU was 19.6 days. The number of admissions by month is outlined in Table 1.

The March jump in admissions following the opening of the WARU on March 1, 1970 has been sustained at two to three times the pre-unit level, thus indicating the desire of a number of women to utilize the hospital in such a program.

Table 1: Number of Admissions by Month

Month	No. Admissions	Percentage
January 1970*	13	3.2
February 1970*	15	3.7
March 1970	25	6.2
April 1970	24	5.9
May 1970	27	6.7
June 1970	41	10.1
July 1970	36	8.9
August 1970	34	8.4
September 1970	30	7.4
October 1970	37	9.1
November 1970	39	9.6
December 1970	29	7.1
January 1971	28	6.9
February 1971	28	6.9

\*The Women's Alcoholic Rehabilitation Unit opened March 1, 1970, which presumably accounts for the lower number of admissions in January and February 1970.

Recidivism has always been considered a major problem in the treatment of alcoholism. The data collected supports the reality that recidivism is a problem, but indicates that its proportion is not as great as is sometimes expected. Table 2 indicates the number of previous Springfield admissions for all patients admitted during these 14 months and Table 3 indicates the number of all mental hospitalizations for these same patients. It should be noted that in Table 2, almost half of the admissions are for the first time and that the percentage coming for each successive admission drops rapidly to 3% by the fifth admission.



**Table 2: Number of  
Previous Springfield Admissions**

1st Admission	—	46%
2nd Admission	—	16%
3rd Admission	—	5%
4th Admission	—	5%
5th Admission	—	3%
6th - 10th	—	11%
11 or more	—	5%

Almost one-half of the admissions are for the first time, and 75% are coming for no more than their third time; only a small number come more than ten times.

Although a few faces are seen many, many times, it is true that in total, only 16% come more than five times. Keeping in mind that the average length of stay is less than a month, it is clear that the alcoholic female patient by and large does benefit from brief use of the hospital, and presumably makes an adequate recovery. Of each 15 women entering for the first time, only one will return for a sixth time.

Table 3 indicates that a number of patients do switch hospitals. Nevertheless, 75% are still not coming more than five times. If 30% are first admissions and only 6% fifth admissions, then five sixths of the patients do not have to return to the hospital more than five times. It should be noted that some patients who do not continue to return die as a result of alcoholism. Nevertheless, this is not the expected outcome for those with few admissions.

Of the 406 admissions, 202 (50%) entered voluntarily, 149 (37%) entered on alcoholic or mental certificates, and 55 (13%) entered on court order. Forty-six of the court order patients came from Baltimore City and nine from all the county areas served by Springfield.

Table 4 shows the area and racial distribution of the patients. Note that six patients were not accounted for in this tabulation.

The average length of stay in tabular form is shown in Table 5.

Demographic data on the patient population indicates a number of problems in life situations outside the hospital, but also shows that no problem is nearly 100% present in each instance, except the problem with drinking. Education is presented in Table 6. At the time of admission, 29% of the patients were married, 25% separated, 12% divorced, 13% widowed, 11% single, and 8% in common-law relationships.

**Table 3:  
Number of All Mental Hospitalizations**

1st	—	30%
2nd	—	17%
3rd	—	11%
4th	—	7%
5th	—	6%
6 - 10	—	16.2%
11+	—	10.6%

Both the first admissions and those who have over five or more admissions are likely to have been to another hospital at some time. Some few have been many times, thus weighing the data in the categories 6-10 and 11+.

**Table 4: Area and Racial Distribution**

Area	Caucasian		Negro		Other		Total	
	N	Pct	N	Pct	N	Pct	N	Pct
Carroll	10	4.2	0	0.0	0	0.0	10	2.5
Howard	4	1.7	3	1.9	0	0.0	7	1.8
Frederick	14	5.9	4	2.5	0	0.0	18	4.5
Montgomery	63	26.6	6	3.7	0	0.0	69	17.3
Washington	10	4.2	3	1.9	0	0.0	13	3.3
Garrett	0	0.0	0	0.0	0	0.0	0	0.0
Allegany	5	2.1	1	0.6	0	0.0	6	1.5
Out of Zone	14	5.9	2	1.2	0	0.0	16	4.0
Baltimore City	117	49.4	143	88.3	1	100.0	261	65.3



**Table 5:**  
**Length of Stay in Springfield and ARU**

	SSH*	WARU**
0 - 14	17%	31%
15 - 28	15%	35%
29 - 42	13%	16%
43 - 56	6%	8%
57 - 70	4%	3%
71 - 84	3%	1%
85+	6%	6%

\*Information not ascertained on 36%

\*\*N=239

**Table 6: Education in Years**

Yrs.	Percentage
0 - 8	23
9 - 11	35
12 -	23
13 - 15	10
16+	6
No data	2

Education, in years, was obtained from only 52% of the patients. Educational level is further reflected in the fact that 60.3% were employed in semi-skilled or unskilled employment. Fifty-three percent had never driven, and only 20% had valid licenses.

**Table 7: Additional Data—ARU Male Program**

**Comparative utilization data for male patients in the ARU covering the period January 1, 1971 through June 30, 1971:**

Month	1st Adm.	2nd Adm.	3rd Adm.	4th Adm.	5th or more	Total
January	53	22	21	7	37	141
February	37	28	12	8	38	123
March	60	26	17	9	40	152
April	65	24	14	14	38	155
May	57	33	17	9	32	148
June	59	30	18	12	26	145
Total+%	331=38%	163=19%	99=12%	59=7%	211=24%	864

**Length of Stay in ARU for Men — February 1-June 30, 1971:**

Days	No. Patients	Days	No. Patients	Days	No. Patients
1	31	8	17	15 - 21	69
2	36	9	14	22 - 28	137
3	39	10	18	29 - 35	66
4	30	11	18	36 - 42	22
5	40	12	12	43+	72
6	29	13	16		
7	35	14	14		
1 week = 240		2 weeks = 109		Average 19.0 days	

This data shows utilization of the ARU by both men and women to be similar in rates of recidivism and length of stay, and again indicates the large number of patients who return not at all, or only a few times, and the short stay required on each admission.

Fifty-three percent had an arrest record. This was weighted towards the younger patients, in that 68% of those from 20 to 35 years of age had an arrest record, whereas only 40% of those over

50 did. Most were for drunk and disorderly, but some 15% had arrests for other offenses. Ten percent had moving violations and 6% were involved in drunk driving violations.



Living arrangements prior to admission were as follows: 27% of the patients were living with their husbands. Eight percent lived with a boyfriend, 10% with parents, 10% with children or other relatives, 18% alone, and 19% with friends or someone else, 18% had come to Springfield from jail, and 13% from another hospital. Although living arrangements were often found to be not good, only 13% wanted help in finding a place to live at the time of their discharge.

One third admitted losing at least one job due to drinking and one third felt they could no longer do the type of work they had done. Three hundred thirteen, or 77%, had no job to return to, and 253, or 62%, felt they needed employment. Yet, only 112, or 27.6%, wanted help in finding employment.

Patients were asked if they felt they had a drinking problem, and 69% said they had. Clinically, there no patients included who, by history, did not have a drinking problem, although some would not be classifiable as addicted.

Twenty-eight percent knew they had some liver disease and 74% indicated neurological symptoms, either acute or chronic. Ten percent gave a history of seizures and 3.4% of diabetes. Most felt their health excellent or good (68%), while 17% thought it fair, and 12% felt it to be poor.

Twenty percent had needed agency help to raise their children (22% had no children).

Much of this demographic information indicates the patients' strong denial of their illness and denial of their need for some kind of help towards readjustment. This is further evidenced by the patients' reasons for coming to the hospital. Forty-two percent said they came because they were forced, but other reasons given were as follows: need help to stop drinking—23%, dry out—9%, family pressure—8%, professional advice—8%, nerves—5%, and end of resources—4%. Again, as indicated by the readmission rates, most do manage to take care of themselves after a time, and perhaps an open admission of need for help by the hospital would not necessarily be to their advantage.

In summary, we feel that the first year of operation of the WARU has shown that the woman who has a problem with alcohol will make use of the hospital and will clearly be benefitted by doing so.

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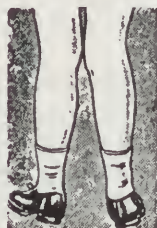
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library

## MEDIA

In the past three or four years the new term for primarily audio-visual methods of presenting information has become "media." This was the subject of the recent conference held in Winston-Salem, North Carolina by the regional Medical Library Association Washington Area Group, hosted by the Bowman Gray Medical School Library and the University of North Carolina Medical School Library.

Speakers came from NMAC (National Medical Audio-visual Center) Atlanta, Georgia, a unit of the National Library of Medicine in Bethesda, Maryland. At one session Miss Margaret Brooks gave an illustrated demonstration on the use and care of various types of audio-visual equipment. With a refreshing brand of humor she extolled the advantages of slides, filmstrips, and tapes, while admitting the pitfalls. Consoling enough, during all the demonstrations the usual mechanical hitches showed up, such as getting the wrong tray of slides shown.

The subject of the Saturday morning program was medical education and the part new media have played in advancing teaching techniques. Charles Bridgman, MD, showed a very modern film version of the history of medicine, which must have left Vesalius reeling in his grave! He then launched into the development of teaching packages using all types of media and arrangements of study areas.

The business meeting was concerned mostly with a proposed change of name for the group since "Washington Area" did not indicate the entire geographical coverage. The name finally agreed upon was Mid-Atlantic Region of MLA, comprising Maryland, District of Columbia, Virginia, West Virginia, and North Carolina. In this way it approximates the geographical designation of the regional library, MARML — Mid-Atlantic Regional Medical Library, actually operated out of the National Library of Medicine, Bethesda.

Mrs. Erika Love, Chairman, reported that some members of this group thought the organization, now very informal and without a structured slate

of officials elected annually, should consider revising this procedure. Heretofore, the hosts for the year have acted as chairman and co-chairman, appointing local committees for program and arrangements as needed. It was suggested that the new chairman appoint a committee to study that matter.

Wilhelm Moll, MD, Director, University of Virginia Medical College at Charlottesville, Virginia, invited the group to meet there next year and automatically became the group's 1972 chairman.

Mrs. Jane Fulcher, Librarian, Washington Medical Center, Washington, D.C., was appointed representative from this region to the Medical Library Association Nominating Committee.

A very useful directory of the librarians in the area had been compiled and was distributed to attendants of the conference. This was the work of the staffs of the two host libraries and should be kept up to date each year, if possible.

Attendance at the conference totaled 115, divided as follows: D.C.-9, N.C.-42, Maryland-34, Virginia-28, Michigan-1 (Mrs. Helen B. Schmidt, MLA Secretary); S.C.-1, W.Va.-0, and visitors and guests-10.

Other speakers were Mrs. Janet Welsh, speaking on "Grants for the small library under the Medical Library Assistance Act of 1965," and Mr. William Caldwell, Biological Services Division, NLM on "AIM-TWX." Next month we can discuss their talks.

\* \* \*

By publication date, Mr. Joseph Jenson, formerly of Denver, will have joined the staff of our library and will be in charge of cataloging and acquisitions.

\* \* \*

Don't forget the library is always open on evenings the Baltimore City Medical Society meets. Come by and browse before you attend the meetings.



## NEW ACCESSIONS - BOOKS

(arranged by subjects)

### DIABETES MELLITUS

Investigative issues in diabetes mellitus. Guest editor: Ruben Bressler. Chicago, AMA, 1969. (Archives of Internal Medicine Symposia, v.1) WB 1 A7 v.1 1969.

### ENDOCRINE SYSTEM

Werner, Sidney C.

**The thyroid: a fundamental and clinical text.** Edited by Sidney C. Werner and Sidney H. Ingbar, New York, Harper & Row, 1971 WK 200 W4 1971.

**The Yearbook of endocrinology 1971.** Chicago, Year Book Medical Publishers, 1971. WK 100 Y4 1971.

### ENVIRONMENT

**Symposium on man on the South Polar Plateau.** Guest editor: Jay T. Shurley. Chicago, AMA, 1970. (Archives of Internal Medicine Symposia, v.4) WB 1 A 7 v.4 1970.

### GYNECOLOGY

Benson, Ralph C.

**Handbook of obstetrics & gynecology.** Illustrated by Laurel V. Schaubert. 4th ed. Los Altos, Lange Medical Publications, 1971. WP 100 B4 1971.

Stevens, Grant M.

**The female reproductive system.** Chicago, Year Book Medical Publishers, 1971. WP 141 S7 1971.

### HOSPITALS

Maryland State Department of Health and Mental Hygiene. Division of Emergency Services.

**Survey emergency ambulance service in Maryland.** Baltimore, Md. State Department of Health & Mental Hygiene, 1971. Ref. WX 215 M3 1971.

Joint Commission on Accreditation of Hospitals. **Hospital survey questionnaire, part 1.** Chicago, JCAH, 1971. Ref. WX 27 J6 1971.

### INTERFERON

**Symposium on interferon and host response to virus infection.** Guest editor: Thomas C.

Merigan. Chicago, AMA, 1970. (Archives of Internal Medicine Symposia, v.5) WB 1 A7 v.5 1970.

### KIDNEY DISEASES

**Divalent ion metabolism and osteodystrophy in chronic renal failure.** Guest editor: Charles R. Kleeman. Chicago, AMA, 1969. (Archives of Internal Medicine Symposia, v.3) WB 1 A7 v.3 1969.

**Symposium on renal transplantation.** Guest editor: Roscoe R. Robinson. Chicago, AMA, 1969. (Archives of Internal Medicine Symposia, v.2) WB 1 A7 v.2 1969.

**Symposium on uremic toxins.** Guest editors: Louis B. Welt, Henry R. Black, Keatha K. Krueger. Chicago, AMA, 1970. (Archives of Internal Medicine Symposia, no.7) WB 1 A7 v.7 1970.

### MEDICAL PROFESSION

American Medical Association

**Current medical information and terminology.** Burgess L. Gordon, ed. 4th Chicago, AMA, 1971. Ref. W 15 A5 1971.

American Medical Association. Center for Health Services Research and Development.

**Reference data on socioeconomic issues of health.** Chicago, AMA, 1971. W 76 A5 1971.

Ferguson, Mary E.

**China Medical Board and Peking Union Medical College; a chronicle of fruitful collaboration, 1914-1956.** New York, China Medical Board of New York, 1970. History W 19 .JC6 F4 1970.

### MISCELLANEOUS

Lynch, Henry T.

**International directory of genetic services.** 3d. New York, National Foundation-March of Dimes, 1971. Ref.QH 431 L9 1971.

Dorsey, John M.

**Psychology of language.** Detroit, Center for Health Education, 1971. BF 455 D6 1971.

Ganong, William F.

**Review of medical physiology.** 5th. Los Altos, Lange Medical Publications, 1971. QP 34 G3 1971.

**Probiotics.** Edited by George S. Sperti. Westport, Conn., AVI Pub. Co., 1971. QW 504 P7 1971.

U.S. National Clearinghouse for Smoking and Health.

**A physician talks about smoking.** Rockville, Md., USPHS, 1971. HV 5733 U6 1971.



U.S. National Institutes of Health.

**The clinical center;** current clinical studies and patient referral procedures. Bethesda, U.S. Dept. of Health, Education & Welfare, NIH, 1970. Ref. W 20.5 U6 1971.

## PRACTICE OF MEDICINE

**The Year book of medicine 1971.** Chicago, Year Book Medical Publishers, 1971. WB 100 Y4 1971.

## PSYCHIATRY

Solomon, Philip

**Handbook of psychiatry.** Edited by Philip Solomon and Vernon D. Patch. 2d. Los Altos, Lange Medical Publications, 1971. WM 100 S6 1971.

Bryson, Carolyn Q.

**Early childhood psychosis:** infantile autism, childhood schizophrenia and related disorders. An annotated bibliography, 1964-1969, prepared by Carolyn Q. Bryson and Joseph N. Hingtgen. Rockville, Md., NIH, 1971. (Publication no. (H.S.M.)71-9062. WS 350 B7 1971.

## REFERENCE

Benton, Mildred

**Library and reference facilities in the area of the District of Columbia.** Washington, D.C., The Joint Venture, 1971. Ref.Z 732 B4 1971.

Duke University. Medical Center Library. Reference Department.

**A list of health sciences libraries in the Mid-Atlantic region (Area IV).** Durham, N.C., Duke University, 1971. Ref.Z 675 .M4 D8 1971.

## REHABILITATION

Sinai Hospital. Department of Rehabilitation Medicine. Baltimore.

**New directions in vocational rehabilitation:** the stroke patient. Edited by Charles Smolkin and B. Stanley Cohen. Baltimore, Sinai Hospital of Baltimore, Inc., 1971. HD 7256. .U5 S5 1971.

## RESPIRATORY SYSTEM

**Symposium on pulmonary responses to inhaled materials:** an evaluation of model systems. Guest editor: Kaye H. Kilburn. Chicago, AMA, 1970. (Archives of Internal Medicine Synposia, v.6) WB 1 A7 v.6 1970.

U.S. Center for Disease Control. Tuberculosis Branch.

**1970 Tuberculosis statistics:** states and cities. Atlanta, U.S. Center for Disease Control, 1971. WF 200 U6 1971.

## SURGERY

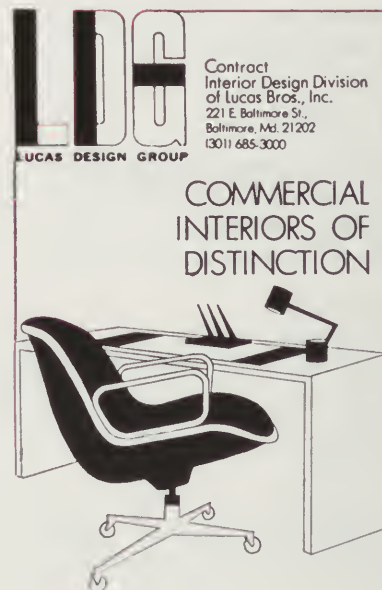
**Year book of surgery 1971.** Chicago, Year Book Medical Publishers, 1971. WO 100 Y4 1971.

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## Technical Exhibitors

(as of November 15, 1971)

Bristol Laboratories  
Herbert Cox, Correct Shoes  
Eaton Laboratories  
Encyclopaedia Britannica, Inc.  
Flint Laboratories  
Graymar Business Machine Co.  
Hoechst Pharmaceutical Company  
Eli Lilly and Company  
Maryland Blue Shield, Inc.  
Med-Chi Automobile Leasing Plan  
Dynatech Cryomedical Company  
Medical Equipment Unlimited  
Merck Sharp & Dohme  
Murray-Baumgartner Co.  
Wm. P. Poythress & Co., Inc.  
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CBS, Inc.  
G. D. Searle & Co.  
Warner-Chilcott Laboratories  
Wyeth Laboratories  
Smith, Miller & Patch



PREVENTIVE MEDICINE IN WORLD WAR II, Volume IX, Special Fields, published by the Department of the Army, Historical Unit, USAMEDS, Washington, D.C., 1971.

The title, Special Fields, for this volume was adopted for convenience to include subjects not readily classifiable in other volumes already published.

Training in preventive medicine of Medical Department officers and enlisted men; health education of troops; occupational health and industrial medicine; disabilities due to environmental and climatic factors; enemy prisoners of war; and research and laboratory support are only some of the areas covered in this comprehensive text regarding the medical services during World War II.

This book is the first definitive one to cover such a wide range of subjects that will be recorded for posterity.

THE FALLING SICKNESS, A History of Epilepsy from the Greeks to the Beginnings of Modern Neurology, by Owsei Temkin, 2nd Edition, The Johns Hopkins Press, Baltimore and London, 1971.

The second edition of this publication brings it up to date, in line with the advances made in neurosurgery, neurophysiology, and electroencephalography. The author, however, elected to have the book remain as a history of epilepsy in Western civilization. He did not extend it beyond the beginnings of modern neurology with the understanding that, there being no exact date for that beginning, the book does not end at any specific date.

To quote the author's words, "I have again been vividly aware of the two opposing tendencies inherent in all historical works: to let the past speak for itself and to bring it near to the understanding of the modern reader."

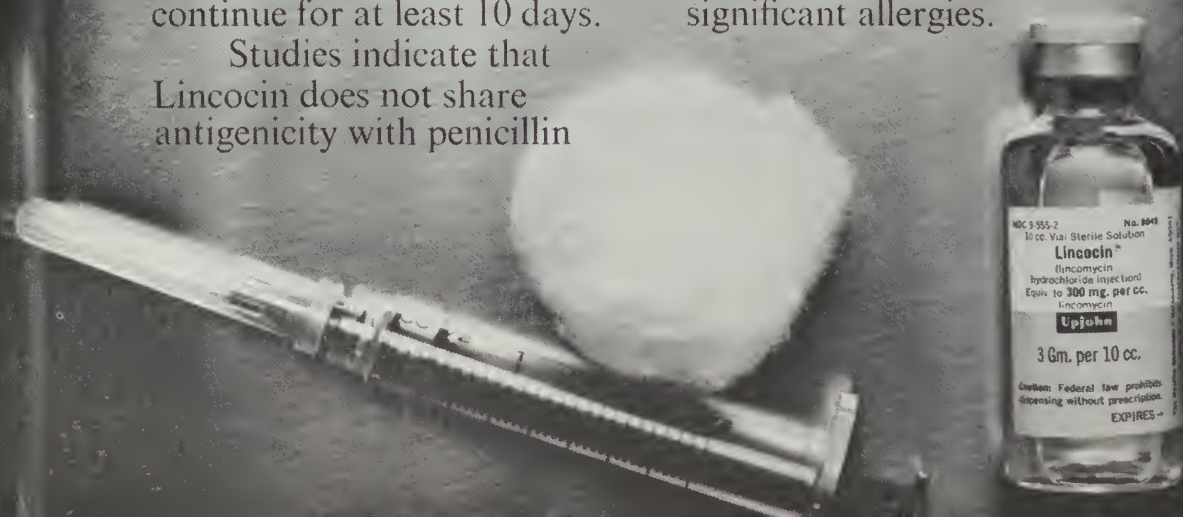


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compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.





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Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with

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**CONTRAINDICATIONS:** History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or

significant allergies. Overgrowth of non-susceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

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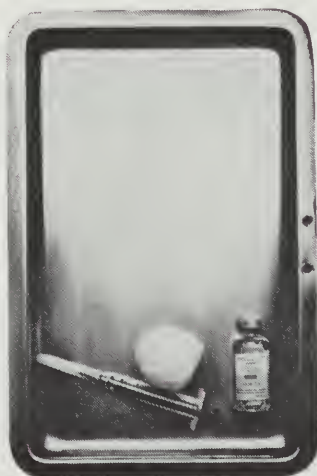
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*John Galsworthy*

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FREDERICK J. BALSAM, MD, EDITOR

## **rehabilitation medicine**

# USE OF PHYSICAL THERAPY IN NEUROLOGICAL DISORDERS

**B. STANLEY COHEN, MD**

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The neurological disorders for which physical therapy may be prescribed constitute a widely diverse group of conditions affecting all age groups. They may be congenital or acquired, the result of disease or trauma, acute catastrophic episodes, or insidiously developing chronic disorders. The assault on the nervous system may be a single one, as in cerebral palsy, with a relatively static course thereafter; or, as in poliomyelitis or Guillain-Barré polyneuritis, with subsequent improvement of greater or lesser degree. It may follow a gradually progressive course, as in Parkinson's disease or amyotrophic lateral sclerosis, or a course characterized by remissions and exacerbations, as in multiple sclerosis.

One or many portions of the nervous system may be involved, of the upper or lower motor neuron or both, of the brain, spinal cord, or peripheral nerves, or all of these.

In an attempt to develop some common denominators useful for the prescription of therapy, a basic procedure must be evolved. Some of the questions which need to be answered are: What part of the nervous system is involved? What is the disease process and what is its natural history? What is the purpose of treatment? Most of the diseases of which we are speaking have no cure. Treatment is therefore directed toward other goals. What are these goals?

If recovery is to be anticipated, as in some of the peripheral neuropathies and entrapment syndromes, the goals would be prevention of deformity or permanent damage due to over-

stretch of weakened muscles, or damage to joints which are left unsupported by guardian muscles. This would be accomplished by splinting and bracing. If the condition is generalized, a more inclusive program would be prescribed. An example would be infectious polyneuritis of the Guillain-Barré type. Here disability develops rapidly, with recovery being made over a period of weeks or months. The principles are similar to treatment following poliomyelitis, which fortunately is not the problem it so recently was.

If the patient is at bedrest for any period of time, the complications of immobilization must be avoided. Bed positioning to prevent contractures, frequent turning to prevent decubiti, and pulmonary complications apply to all such conditions. Where possible, exercises should be prescribed for unaffected muscles in the body to prevent deconditioning due to disuse. Relief of pain due to muscle spasm may be accomplished by the local application of heat and massage. Re-education and strengthening of weakened muscles by therapeutic exercises would be prescribed as the acute stage subsides. This would progress from passive exercise, with the therapist providing the motion, to assisted exercises, with the patient attempting to assist the therapist, then, as strength increases, with the therapist assisting the patient. The next stage is active exercises by the patient. When strength is sufficient for movement of a part through its range of motion against gravity, strengthening is begun by the addition of resistance. This may be manual resistance applied by the therapist or progressive graded



resistance employing weights or equipment. When strength is adequate, transfer and ambulation activities are begun.

If bedrest has been prolonged for any period of time, there has been alteration in the ability of the body to adapt to changes in position. Studies involving immobilization in bed of healthy young men have shown that one of the first changes to develop is the loss of vasomotor response to the upright position, with hypotension, insufficient cerebral vascular perfusion, and fainting. It occurs within several weeks in the healthy young man, and more rapidly in the elderly and the ill. This change must be taken into consideration in patients beginning a treatment program. Sitting tolerance can be developed by gradual elevation of the head of the bed, by sitting at the bedside, and gradual standing, using elastic bandages on the legs and, in some cases, abdominal binders.

### Treatment Tools

Where available, a very useful treatment tool is the tilting board or tilt table, on which the patient may be gradually elevated to erect posture, while being monitored for blood pressure drop or pulse rate increase. Tilt tables, with hand cranks or motorized, are available in hospitals and nursing homes. Simple tilt boards may be constructed easily of supported plywood for use in small hospitals, nursing homes, and in selected instances in the home, with minimal instruction to personnel.

When the patient can adapt to the upright position, ambulation may be begun. Parallel bars may be used, or simulated by placing heavy chairs in a row with the backs facing. Progression to a walkerette (we prefer the lightweight portable walkerette to the wheeled walkers), crutches, and canes follows as strength returns. The goals of the treatment just described for the acute case with anticipated recovery must be modified where recovery of function is not anticipated. An example would be spinal cord injury or disease with paraparesis or paraplegia. Here, the treatment goals and the treatment program are different. If permanent paralysis occurs, treatment for the paralyzed parts would be prevention of contractures which might interfere with care and mobility, prevention of skin breakdown due to pressure sores, and modification of spasticity where possible. The bulk of the program would be aimed at the uninvolved extremities. In the paraplegic, strengthening of the upper extremities is vital.

The patient is taught to "walk on his hands" with crutches or special canes and to transfer to and to be functional in a wheelchair. The development of supernormal strength in the upper extremities is accomplished with continuous weight lifting and mat work.

### Ambulation Goals

A few words are in order regarding ambulation goals in the cord-injured patient. Those with cervical cord injury are wheelchair bound and frequently require attendants. Those with thoracic cord injury are usually not functional walkers. They may get around with heavy bracing and crutches but the energy demands of ambulation are high and, except for the young, slender athletic male, few patients sustain ambulation. They discard their apparatus and return to the wheelchair soon after discharge from the rehabilitation center. This does not mean that such training is worthless. It serves metabolic and psychologic functions and ambulation is useful in certain circumstances; but, as an overall goal, wheelchair existence is more realistic. The lower lumbar cord and cauda equina patients who have good back and abdominal muscles may ambulate with crutches or Lofstrand canes.

What are the goals in the patient with remissions and exacerbations, as for example the multiple sclerosis patient? Here the course varies from patient to patient and from time to time in the same patient; the program must be more individualized. A few generalized rules may be applied, however. The value of exercise during the acute stage is questionable. Some feel that exercise in the acute stage has no influence on the course, others think it to be actually deleterious. Active exercise programs are therefore usually reserved for times when the situation has stabilized between exacerbations. This does not mean that physical therapy should not be prescribed during the acute stage. As in most other conditions affecting the neuromuscular system, therapy is in order for proper bed positioning, passive range of motion exercises to prevent deformity and contractures, skin care, and sometimes supportive splinting. The trained physical therapist is not always needed. In some instances a nurse or an attendant, properly trained, may accomplish the goals.

In all situations involving the musculoskeletal system, particularly where loss of mobility and loss of muscle strength are present, early pre-



ventive measures, such as mentioned here, seriously affect the later function. Many of the patients seen in rehabilitation settings are there because of the complications arising during acute care: contractures, decubiti, joint damage, peripheral nerve injuries secondary to pressure, and handling. Much time and expense must be devoted to the correction of preventable complications before attention can be directed toward restoration of the function lost as a result of the primary process itself.

Thus far, we have considered the acute process with recovery, the single insult with a relatively static course, and the remittent conditions. A large number of neurological conditions are progressive degenerative conditions. A common example is Parkinson's disease. A less common condition is amyotrophic lateral sclerosis with its variants.

### Different Goals

Here the goals are different. Recovery is not anticipated. The process often cannot be arrested. We fight a delaying battle, recognizing our ultimate defeat in many cases, but working to maintain function as long as possible.

In the Parkinson patient, treatment depends on the presenting manifestations. Exercises are prescribed to prevent contractures. These usually develop at the knees, hips, and shoulders. Active exercises are prescribed. Hamstring stretching is often necessary.

Gait is frequently a problem. Associated arm movements are lost, reciprocal movements are affected, the center of gravity is altered, and postural problems develop. Coordination is affected. Treatment programs are directed at improving posture, and in providing exercises for coordination and reciprocal movements. Gait training involves teaching longer stride length and a broad based gait for turning. The stationary bicycle is effective for reciprocal movements, range of motion in the lower extremities, and general conditioning.

In the upper extremities, the nature of the tremor frequently produces a deformity of metacarpophalangeal flexion and interphalangeal extension. Treatment here by occupational therapy techniques is often effective. Craft activities including work with clay not only provide therapeutic exercise, but serve diversional functions as well.

Other problems of the Parkinson patient may

be aided by the speech clinician. Drooling and loss of force in phonation may be helped by exercises for the mouth and pharynx and by breath control exercises.

Of importance in the treatment of the Parkinson patient is the recognition of two factors. First, treatment will delay invalidism even while not affecting the disease process. Secondly, the program does not have an end. It is a lifetime maintenance program. Once the specific problems have been corrected to the greatest possible degree, the patient and family must be enlisted in a maintenance program on a regular basis. This often requires careful explanation of the positive aspects of the program and counseling of the family.

In our setting, we have found group treatment to be a very effective means of handling these patients. At Sinai Hospital we have established several groups who are seen twice weekly for physical therapy. This consists of mat activities, walking activities, and ball playing; and for occupational therapy consisting of group craft activities. In addition, the patients eat lunch together, at which time problems related to tremor and rigidity are handled, with instruction and the introduction of modified eating utensils. Another group works with the speech clinician on exercises to control drooling, maintain voice volume, and encourage speaking. While the patients are involved, the family members meet in group discussion of mutual problems.

### Nerve Injuries

Physical therapy may be prescribed in peripheral nerve injuries of various sorts.

In radial nerve injury, such as radial nerve pressure palsy, where recovery occurs often in four to six weeks, little or no therapy may be needed. A wrist cockup splint may be of value in preventing overstretch of the weakened wrist extensors. Grip strength is much better in the functional position of extension than in the deformed flexed position. The splint may enable the patient to continue at work.

In sciatic nerve and peroneal nerve injuries, foot drop may be managed with a short leg brace or foot drop support to prevent overstretch of the dorsiflexors, to prevent heel cord contractures, and to facilitate safe walking, pending the return of function.

In Bell's palsy, taping of the facial muscles may prevent muscle sagging, facilitate eye



closure, and partially overcome the psychologically disturbing facial deformity pending return of function.

In many patients, with peripheral nerve injury, direct current electrical stimulation is of value in preventing edema and assisting in the discharge of muscle metabolic products. Although muscle stimulation does not hasten return, it has been shown to be effective in delaying muscle atrophy. If muscle atrophy can be delayed and fibrosis prevented, muscles can be expected to function more effectively following re-innervation.

In the peripheral nerve injury, as re-innervation occurs and muscle function begins to return, re-education and strengthening may proceed, as previously described.

Several procedures of a diagnostic nature are worthy of mention in speaking of peripheral nerve injury and other lower motor neuron disease. Some of the older methods of electrodiagnosis depend on differences in the response of innervated and denervated muscle to alternating and direct current. Among these are strength duration curves and chronaxie determinations, which may be of value in diagnosing the presence of lower motor neuron disease and assisting in localization. Many physical therapists are equipped and trained to perform these tests, which can be expected to become positive 14 to 21 days following partial or complete denervation.

The newer methods of study are based on the nature of the conduction process in nerve and the electricity generated by contracting muscle. These studies, requiring more sophisticated equipment and specialized skill, are electromyography and motor and sensory nerve conduction velocity studied. Carefully performed, following careful neurological examination and muscle testing, they are of value in differentiating upper and lower motor neuron disease; myopathy and neuropathy; and in the localization of involvement within the lower motor neuron to anterior horn cell, root, plexus, nerve, motor end plate, and muscle.

In discussing the prescription of physical therapy, some mention should be made of nerve root compression in the neck and back. Treatment by physical therapy techniques may often be effective. Patients who have nerve root compression in the neck as the result of injury often respond to initial rest in a cervical collar, followed in a matter of days by heat and massage to overcome pain and muscle spasm. Cervical traction is effective in overcoming root

compression and preventing the development of adhesions secondary to ligamentous tears. It may be applied by motorized techniques or manual Sayre-type traction. Usually 25 to 35 pounds of traction are required for effective treatment. In cases of ligamentous injuries without root compression, pain and disability are overcome by the early use of the neck exercises to regain mobility. Strengthening of the neck flexors is often helpful. In this type of injury, long term immobilization in a collar tends to perpetuate disability. Heat, massage, and an active exercise program have been shown repeatedly to be effective.

Traction in the low back is not nearly as effective as in the neck. Its major value is in enforcing bedrest. Heat and massage relieve pain and muscle spasm. A supporting garment may afford relief of pain. Following the acute phase, a progressive exercise program for abdominal and back muscle strengthening should be prescribed. It should be emphasized that heat and massage are temporarily palliative measures, but are not definitive therapy in themselves. They are of value in affording relief in the early stages. Thereafter, their value is largely as preparation for the therapeutic exercise program.

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# Changing Attitudes and Practices Concerning Abortion: A Sociomedical Revolution

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*This paper was presented on May 12, 1971  
during the 173rd Annual Meeting of the  
Medical and Chirurgical Faculty at the  
Baltimore Civic Center.*

My purpose is to trace landmarks in the history of abortion and then give my reactions to some of them. Finally, I would like to discuss the extraordinary experience we are having with abortion in New York since the law was repealed.

Abortion has been a medical topic for discussion as long as medicine has been recorded. Three of the very earliest medical records we have, 4,000-year-old Egyptian papyri, are replete with references to abortion and contraception. Actually the earliest medical document which has come down, a Chinese herbal which is 5,000 years old, recommends mercury as an abortifacient.

Abortion was referred to only once in either the Old or the New Testament. It is an interesting reference found in the Book of Numbers, Chapter 22. If two men are vying with each other — I assume some kind of Chinese wrestling — and by accident one crashes into the belly of a pregnant woman, if no *harm* results, then a fine may be exacted by the husband; but if harm results, a life for a life.

This is interpreted to mean that if the pregnant woman simply miscarries and does not die, then the husband may exact a fine. On the other hand, if she should die, then theoretically the guilty wrestler would be charged with the deed and a life for a life exacted as the penalty.

This passage was translated quite differently in the Septuagint. As you remember, Alexander assembled 70 great scholars to translate the

Masoretic Hebrew text into Greek. Apparently the Hebrew word "ason" can either be translated as "harm" or "form." The translators of the Septuagint chose to translate it "form." Therefore, it reads in the Greek translation that if no "form" has occurred, then the husband can exact a fine; but if "form" has occurred then a life for a life.

This has had impact on theological considerations. Form means resembling an embryo. If that is the case a serious sentence can be meted out; but if it's only a glob of material, a formless mass, then only a fine can be exacted.

Several Greek philosophers were deeply concerned with the control of conception through abortion or contraception. Plato, in protecting the ideal city state, arrived at the figure of 5,040 citizens as the desirable size to "furnish numbers for war and peace, for all contracts and dealings including taxes and divisions of the land."

In the sixth book of *The Republic*, he expresses his code of positive eugenics. He was probably the earliest eugenicist. He said, "It follows that the best of both sexes ought to be brought together as often as possible, the worst as seldom as possible, and that we should rear the offspring of the first but not the offspring of the second. We must then have statutory festivals at which time we bring together brides and bridegrooms. The number of marriages we shall place under the control of the rulers that they may, as far as possible, keep the population at the same level, having regard to war and disease, that our city become neither great nor small."



He also felt that there was an ideal age for humans to reproduce. "Children must be born from parents in their prime. For a woman, the proper time is to begin at 20 years, and bear children for the city until she is 40. For a man, to beget children for the state until 55. In both cases that is the period of their prime both in body and in mind."

"Then I fancy that the men and women past the age of having children (shall be) at liberty to associate with whomever they please — only after we have exhorted them to be very careful that they should not bring forth a child. If one should be conceived it should not see the light; but if one should, they must dispose of it".

Plato looked upon abortion as a useful and necessary procedure. His application was largely eugenic. You realize that infanticide was practiced very widely in both classic Greece and Rome, so that if the woman could not be aborted, then her infant was dispatched.

There is great confusion on the part of theology as to when life begins. Its inception was associated with the vague process of ensoulment. What greatly confused the Church was when the soul first inhabited the body.

Aristotle came to the conclusion that life began 40 days after conception for a male fetus and 80 days after conception for a female fetus. This belief was long held, for Aristotle's opinion had great weight.

The Church, the Christian Church, has been continually confused about the time of ensoulment and has changed its opinion on many occasions. St. Gregory and St. Augustine back in the fourth and fifth centuries thought that life began with the actual process of conception, and then Thomas Aquinas, the great church philosopher, reasoned that life did not begin until the fetus moved, because this was the first evidence of life. Therefore, Pope Gregory IX in the thirteenth century ruled that there was no sin to abortion before a fetus first moved.

This was the accepted opinion of the Church until 1591, when Pius IV said that life commenced 40 days after conception and abortion was only proper and legal within the first 40 days. After 40 days it became a serious crime.

Pius IX, in 1869, brought the sin back to the time of conception. For the last 102 years, the Church has held that abortion is a crime beginning with the moment of conception. Previous to 102 years ago, it was believed that abortion was no sin within the first 40 days. However, the Catholic Church now is crystal clear where it stands in this whole area today.

Any abortion at any time is to be irrevocably condemned.

In regard to law, the common law held that abortion was no crime until a fetus had moved. This was the common law of England, accepted in this country. It was finally changed by Parliamentary statute in England in 1803. In 1803 it was decided by Parliament that abortion was a crime from the moment of conception, but that it was a much more serious crime if fetal movements had occurred.

### First U. S. Laws

In the United States we had no specific statute concerning abortion until Connecticut passed its first law in 1820. Previous to that, all states followed the common law of England, allowing abortion until the fetus moved. In 1820, Connecticut made abortion a crime at any time.

In 1828, the State of New York was the first to create an exception. It passed a statute ruling that abortion may be legally performed to preserve the life of the mother. This is the first time such a phrase appears in any law.

Professor Cyril Means, an excellent legal scholar, researched the law and discovered that in 1828 when the New York statute was passed it was passed by a Protestant legislature, not on theological grounds but purely to protect the health of women.

### Hospital Records

We have records from the New York Hospital from 1803 to 1830. Between these dates there were eight therapeutic abortions performed at the New York Hospital. Three women died and five recovered, a maternal mortality of 37.5%. This was before asepsis, before antibiotics, before anesthesia, before transfusion. And in the same hospital, during the same period, the maternal mortality from childbirth was 2.8%. Thus there was a mortality from abortion of 37.5% and from childbirth, 2.8%. Therefore the legislators argued that abortion, being so hideously dangerous, should only be performed if the physician thought that the woman's life was more likely to be sustained, protected, and preserved by this very dangerous procedure rather than childbirth. This was the genesis of the New York law.

If abortion had been safe and relatively without danger at this time in history there is every likelihood no such law would have been passed.



When I became a house officer at The Johns Hopkins many years ago, I began to develop doubts about justifying abortion. It seemed to me that things happened that were difficult to justify.

### Recollections

I recall that in my second year of residency, a social worker brought in a child who was 12 or 13 years old, impregnated by her father. The father had been indicted and was in jail. The social worker quite logically requested that the child be aborted; she was then seven or eight weeks pregnant. Being young and idealistic, I was morally indignant and agreed abortion should be done. I went to Dr. J. Whitridge Williams and put the case to him. He said, "Guttmacher, you know the law of the State of Maryland." I said, "Yes, sir, to promote the safety of the mother." He said, "You can't abort this child for her life is not in danger." I said such conservatism did not make any sense to me.

Dr. Williams told me that if I went downtown and got the state's attorney to write a letter saying that I could legally abort the child at The Johns Hopkins Hospital, I could do it. Naively, I went to see Mr. Wells. Mr. Wells said, "Dr. Guttmacher, mine is an elective post. You can't believe that I would write a letter to The Johns Hopkins Hospital telling them to break the law of the State of Maryland. But please, tell Williams to abort that girl."

I returned to The Hopkins and recited the conversation in detail to Dr. Williams. He said that we could not perform an abortion. And I delivered the child of her father's seven months later. This is one experience that convinced me that conservative abortion laws were not ideal.

### More Recollections

I vividly recall a 15-year-old girl profoundly infected by a botched abortion. The senior staff consulted for an hour debating whether the child's life was more likely to be spared by hysterectomy or prayer. This was before there were antibiotics and transfusion was uncommon. They decided to operate and the girl died four hours later.

Perhaps the thing that affected my opinion most profoundly was the case of a very nice woman named Knight who aborted herself or had been aborted after her fourth baby. Unlike

most people who die, Mrs. Knight protested death because of her children within three minutes of actual demise.

At about this time, one of my colleagues and his wife who had had two children did not want a third. Abortion was performed by one of the senior staff. Across the chart was written "mal-nutrition."

These several experiences as a young physician created doubts in my mind. I became skeptical that this was the way things should be.

In the early thirties, the head nurse of the Women's Clinic called me one day early in my practice years and asked if I would see a father and daughter. He identified himself as a divine from Frederick, Maryland. His daughter had sinned and he wanted to have the sin removed. He had come to Baltimore and didn't know what to do. He had asked several people to recommend a good abortionist, but he became so confused that he finally contacted The Johns Hopkins Hospital and the nurse referred him to me. I suggested a local physician to him.

### Early Challenges

These various happenings made me an iconoclast and I began to challenge the law, not by action, but by speech. In the early thirties, The Hopkins medical students invited me to stage a meeting to discuss abortion in Hurd Hall. I concluded that all that need be done was to liberalize the existing conservative laws. I preached reform for two reasons. Number one, existing laws promoted illegal abortion which was easy to get and extraordinarily discriminatory. Illegal abortion was highly discriminatory because its safety was based on what one could afford to pay.

In the second place, from what I could observe, minority groups and people from the wrong side of the tracks had almost no chance for relatively safe illegal abortion. People on the right side of the tracks had a reasonably good opportunity. I believed that these problems could be straightened out by modifying the conservative laws.

In 1959, my twin brother was a member of the American Law Institute. He informed me that this group of legal scholars was going to meet in New York at the Harvard Club on a December afternoon and that Professor Wexler of Columbia was going to reveal a new abortion law, the now famous ALI law, and he asked if I wanted to come. Of course, I did.



The group of 30 sat around an excessively large round table. Wexler explained the new ALI bill: abortion to preserve life and health; abortion for eugenic indications; abortion for sex crime. I did not think the law was too conservative, as did one elderly judge. Later I was able to take stock. The first states to liberalize their abortion laws accepted the ALI model. Within the first year, 1967, five states including Maryland had liberalized their abortion statutes. After taking stock of results in these states, it became obvious that such liberalization was not the answer to the abortion problem. Partial liberalization did not eliminate illegal abortion nor discrimination. The accumulated evidence persuaded me that no abortion law is the best abortion law; that abortion should be, like other medical procedures, a decision between physician and patient. I admit it took much soul searching to come to this conclusion, but I feel it is the right decision.

### **Hawaii, Washington**

Hawaii was the first state to remove abortion from the criminal code and to place abortion on a basis similar to other medical procedures. Alaska was second, then New York, and fourth the State of Washington. These are the states which have made abortion legal on request.

The State of Washington is particularly interesting because abortion had never been previously decided by popular ballot in any political jurisdiction. It was placed on the ballot in Washington on November 3, 1970. I visited Seattle to speak in behalf of repeal — and I thought that the chances for repeal were remote because there was tremendous agitation by the opposition. Much to my surprise when the popular vote was counted, 56% voted in favor of abortion on request and 44% opposed it. This then is the first time abortion sentiment was tested by popular vote.

### **New York Statistics**

New York State has the most liberal abortion law in the world — and I say the world advisedly. New York's law reads that any woman who is less than 24 weeks pregnant may be aborted if she requests it, provided the procedure is performed by a licensed physician. There is nothing in the statute specifying age, marital status, approval of spouse, or place of residence. Also, nothing in the law specifies where abortion should be performed.

Regulations have been promulgated by the New York State Board of Health and by the City Board of Health. By state rules, in force outside of New York City, abortion can be performed in a private office; according to the City Health Code, it can only be done in a hospital or in the outpatient department of a hospital or in a free-standing clinic approved by the City Board of Health.

Information on abortion results for New York State, outside of the City of New York, is very fragmentary. But there are excellent statistics on what is occurring within the city of New York. It is estimated that two abortions are done in the city to one in the state outside of New York City.

For the first ten months under the new law, beginning July 1, 1970, through April 30, 135,000 legal abortions were performed in New York City. On that basis, 160,000 to 165,000 will be done during the first year of the new law. Probably about 80,000 abortions will be done in the rest of the state. Adding the two makes about a quarter of a million legal abortions within the jurisdiction of New York City and state in the first 12 months of the new law.

### **Delayed Applications**

One problem has been that those seeking abortion come late. The maximum duration allowed by law is 24 weeks. In the first two months of the new law, July and August, only 68% of the patients were less than 12 weeks pregnant. During January and February, 77% were less than 12 weeks pregnant. This still leaves 23% more than 12 weeks pregnant — much too high a figure.

The Eastern European socialist countries and Japan show excellent morbidity and mortality figures because they have such a high proportion of early cases. Ninety-six percent of the abortions performed in the Eastern European countries are performed on women less than 12 weeks pregnant, about 95% in Japan, while in New York City we have only worked up to 77%. There is a five times greater mortality and morbidity in late cases than in early cases.

Of the cases that have been aborted, 51% are residents of states other than New York; 49% are residents either of New York City or New York State; 55% are unmarried; 14% are widowed or divorced; 31% of the pregnancies were achieved in marriage. The maximum number of patients are between the ages of 20



through 24. In second position are those below the age of 20 — between 15 and 20. Of great importance to me is the fact that minority groups are for the first time to my knowledge being properly represented.

Dr. Ed Gold did an excellent study in 1962 on legal abortion in New York City. Abortion then was very uncommon. The abortion incidence in proprietary — the private nursing home type of hospital — was 3.5 per 1,000 deliveries. In the voluntary hospitals, it was 2.5 on the private service and 0.5 on the ward service. In some municipal hospitals one legal abortion was performed for every 10,000 deliveries. Certainly these 1962 data bespeak discrimination.

I am proud of the fact that the municipal hospitals are doing a spectacular job in legal abortion. Of the first 135,000 abortions, 35,000 have been done in 16 municipal hospitals. Furthermore, 24% have been done on Negro patients and Negroes are 18% of New York City's population; 4% have been done on Puerto Rican patients who form 8% of New York's population. To me this signifies that discrimination in abortion has been eliminated to a very large degree.

### Pseudo-Rackets

It is true that there are pseudo-rackets growing up. Some legitimate physicians are becoming extremely rich from performing legal abortions. Some of the proprietary hospitals have been bought by Englishmen and have become abortoria. Several developments such as these may not be socially ideal, but at the same time there are nonprofit abortion services. The Woman's Medical Service of which Dr. Allan Barnes is now Chairman does 100 abortions a day. It only accepts patients referred by ministers. The standard fee is \$200. They only take cases less than 12 weeks. The young patients leave in the afternoon after the procedure has been performed in the morning, many from out of state.

New York City Planned Parenthood anticipates opening a clinic on the first of July which will be several blocks from Beth Israel Hospital. There will be an affiliation between the clinic and Beth Israel. Beth Israel will admit any emergency case which originates in the clinic. They hope to do 7,500 abortions a year and it is contemplated that the fee will be \$80, a cost figure.

### Abortion Law

What is the new law doing to illegal abortion? It is difficult to determine. I would like to share with you the interesting news from the Chief Medical Examiner of New York, Dr. Milton Helpern, who was not very enthusiastic about the new law. Helpern reports that there has been no death in New York City from illegal abortion since September 1970. There were seven deaths from illegal abortions during July, August, and September — the first three months of the new law.

We are beginning to collect data on hospital admissions for incomplete abortion which is one of our best community indices of the prevalence of illegal abortion. At two of the largest municipal hospitals in New York City, comparing July 1 to December 31, 1970 to July 1 to December 31, 1969, the admissions for incomplete abortions were reduced 47%.

According to the City Health Service, ten of the municipal hospitals have averaged 480 admissions for incomplete abortions a month. The new figure shows that the ten hospitals reported 280 admissions for incomplete abortion during the month of February 1971.

What about mortality? Mortality is still higher than we would like it to be. There have been eight deaths in 135,000 cases, a mortality of 6.4 per 100,000 operations. This does not equal the excellent results reported from Hungary, Czechoslovakia, and Japan. But again I remind you that New York City is dealing with a much higher proportion of late cases.

### Educational Methods

I believe that the medical profession has a great responsibility in this whole area. First, we have to educate the American public that the first line of defense against unwanted conception is not abortion. It is effective contraception. This is a very important message. Abortion is and never will be a satisfactory substitute for contraception. Our second obligation is to educate the American public that each individual must make up her mind as early as possible whether or not she wishes to continue pregnant and, if she does not, then she must seek safe abortion as quickly as possible.

The best way to handle the abortion problem is to prevent unwanted conceptions, but realistically we are not likely always to do that. Therefore, a back-up mechanism is needed. And if there is need for a back-up mechanism, it must be safe, nondiscriminatory, legal abortion.



# Replantation of Amputated Extremities: Present Status

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*This paper was presented on May 12, 1971 during the 173rd Annual Meeting of the Medical and Chirurgical Faculty at the Baltimore Civic Center.*

In May 1962, an amputated human extremity was successfully reattached for the first time. The patient was a 12-year-old boy who sustained amputation of the right arm in a train accident. He was taken to the Massachusetts General Hospital where Dr. Ronald Malt assembled a surgical team and reattached the extremity.<sup>1</sup>

As is usually true, the MGH success was the culmination of many years of interest and research in the field of replantation. Numerous legends, caricatures, and crude accounts demonstrate that for several centuries, men have been interested in replanting amputated parts. It is hardly surprising that early attempts were not successful.

The first scientific experiments dealing directly with replantation were begun by Dr. Halsted in 1882, when he divided all the structures of a dog leg except the femoral artery and vein, repaired the severed structures and then, after varying intervals, divided the artery or the vein. His interest was generated by observing postmastectomy edema. It is extraordinarily interesting that Dr. Rienhoff participated in some of these experiments. Dr. Halsted did not publish this work until 1922, and his early experiments were not generally known prior to publication.<sup>2</sup>

In 1903, a German investigator, Hopfner, divided all structures of a dog limb, resutured them and had one animal live for 11 days with a viable limb.<sup>3</sup> Carrel and Guthrie did the same thing in 1906 and had an extremity survive for about 72 hours before it became gangrenous.<sup>4</sup> It is of current interest that Carrel actually transplanted a limb from one dog to another in 1908 and this extremity survived in a viable state for three weeks.<sup>5</sup> Following this flurry of scientific interest in replantation, very little experimental work was reported in the years after 1908,

although it is obvious that the development of vascular surgery during this period of time contributed a great deal to the knowledge that would ultimately lead to replantation.

In 1960, a Russian scientist, Lapchinsky, reported many experiments on limb replantation in dogs and was able to replant extremities in a small percentage successfully.<sup>6</sup> The work of Lapchinsky and, perhaps more importantly, the clinical experience of Malt resulted in renewed interest in the subject of replantation.

In 1962, Dr. Donald Carter and I decided to try to answer a few questions not clarified by the experimental work reported previously.<sup>7</sup> The hind limbs of a series of dogs were amputated using a meticulous, sterile technique. When the procedure was completed, the dog leg was simply put aside in the laboratory and no attempt was made to influence its temperature. No perfusion or anticoagulant therapy of any sort was given any animal. After varying periods of time, we surgically replanted these extremities.

Dr. Gael Frank, from the Department of Orthopedic Surgery, worked out a method of fixation of the femur in the dog (which is somewhat more difficult, interestingly enough, than it is in the human). Dr. Frank also collaborated in our clinical experiences. The bone is stabilized first because the necessary orthopedic hardware could rip asunder any vascular anastomoses that preceded. Following repair of the bone, the vessels were sutured. One rapidly learns to do the venous anastomosis before the arterial. A question asked of these experiments was whether the vascular anastomoses could be done with routine instruments and techniques since, at that time, we and others were interested in magnification techniques. As illustrated in Figure 1, routine





Figure 1: Vascular anastomosis in experimental replantation. Note standard instruments and technique.

vascular surgical instruments were used with no magnification of any sort. Following repair of the vessels, the nerves, muscles, and skin were sutured and the animals allowed to recover. At varying intervals, the long-range survivors were sacrificed and autopsies performed.

These experiments were designed to answer three questions. The first question was simply how often can one replant an extremity with success in the animal. In a total of 16 experiments, four animals died before the experiment was completed. Of the 12 animals that survived the operation, the extremity survived in nine. These results indicated that the procedure of replantation can succeed in salvaging the extremity in a high percentage of experiments.

The second question concerned the importance of time in successful replantation. When replantation was completed between one and four hours after amputation, two of five animals survived. All three operative failures were in this group. After four to six hours there were no failures in six attempts. In the one animal that survived replantation after six hours, the extremity survived. Four animals were lost in attempts to enlarge this group. The cause of their death is a matter of interest and current investigation.

The third piece of information sought was some idea of functional return. All we could really say about the animals is that a large percentage of them did walk on the extremity. Almost all would withdraw from painful stimuli which indicated some return of sensation. There is no question that the extremity was not normal. All the animals had a foot drop. This

answer is obviously less complete in terms of clinical application than the answers to the other two experimental questions.

These experiments and many others, of course, have added a good deal of information to the field of replantation.<sup>8</sup> Clinical reports have begun to appear with regularity following the Malt report. Up to the present time, there are in excess of 50 human replantation operations reported in the literature.<sup>9-10</sup> Many of these are in obscure foreign journals, and it is difficult to give an exact number because these reports have been picked up and added to other series. Clinical reports vary enormously in completeness and accuracy and a great deal in the length of follow-up. The information gained from reviewing the collective series is helpful but should not be considered conclusive.

### General Points

The first general point that might be made is an observation regarding the age of the patients. Replantation of extremities has been performed from age 2½ years to nearly 60 years. The best results have been in young patients. The 2½-year-old child reported by Rosenkrantz probably has the best result of all reported upper arm replantations.<sup>11</sup> The observation that young people do better, of course, is commensurate with the long-known fact that nerve regeneration is more complete in young people. Replantation should rarely be attempted in a person past middle age.

A variety of wounding agents has been encountered in the collected experience. Clean, incised, distal amputation sites give better results than avulsion injuries or other types of crushing injuries. The best results have been in guillotine-type injuries. Contamination of the wound is a relative contraindication to an attempted replantation.

There are no reports of long-range successful replantation of lower extremities, although several attempts have been reported and several others are known.<sup>12</sup> The reason for this is principally the difference between function of the hand and of the foot. The anesthetic, shortened leg is indeed a hazard to the patient. At the present time it seems prudent to suggest that lower extremity replantation not be attempted until we can deal more effectively with peripheral nerve injury. One of the "spin-offs" of the experience with replantation has been the salvage of badly damaged but incompletely amputated extremities. There seems to have been a tendency to more completely assess pa-



tients with badly injured extremities, both lower and upper, and to operatively salvage some that undoubtedly would have been summarily amputated even a few years ago. I think this is indeed an important aspect of the interest in replantation.

It is obviously important to know how long after amputation replantation might be successful. There is a good deal of evidence that skeletal muscle will survive at normothermic temperatures up to six hours and probably up to eight hours.<sup>8</sup> Clearing the vasculature by perfusing it with a balanced electrolyte solution should extend this period. Cooling has been the time-honored method of preserving the extremity. In the Russian experience, one extremity was successfully replanted 24 hours after its amputation, having been cooled during that period of time.<sup>6</sup> The likelihood of infection and the marked accentuation of the cardiovascular effects of revascularization lead to the suggestion that replantation not be considered when the time interval between amputation and restoration of flow is likely to be beyond eight hours. This is conservative, but it is of interest that in the reported experience no extremity has survived after an ischemic period exceeding more than seven hours.

The technical aspects of replantation have been pretty well standardized. It is extremely important to shorten the bone. This allows muscle repair. It is not necessary for vascular and nerve repair, although it is helpful. Bone fixation can be by whatever method seems most appropriate. The venous anastomosis follows and as many veins as possible should be repaired. It is almost mandatory to restore two veins. This is followed by arterial anastomosis, which is easier and which technically creates fewer problems than the venous repair.

The management of severed peripheral nerves is controversial and beyond the scope of this paper, but the tendency has been to do primary repair of the nerves only in those relatively rare situations in which the nerves have been cleanly severed. The most common method of handling the peripheral nerves has been to do early secondary exploration and formal secondary repair. The current methods of handling peripheral nerve injury represent the greatest single limitation in the field of replantation. The closure of skin and muscle is routine, but most have felt that drainage of some type is indicated.

The problems encountered in the postoperative period in our own experience and that of others might be divided into problems

which are encountered early and those that are encountered late. The most obvious early problem is failure of the circulation. This is more commonly due to inadequate venous drainage than to lack of arterial inflow. Failure of the circulation is not subtle. Generally, one can tell within an hour or two of the replantation procedure whether or not the circulation will be adequate. The most common cause of early failure, both clinically and experimentally, is infection and this leads to emphasis on thorough debridement. Occasionally, in experimental animals and in humans, shock has been reported, usually beginning within an hour after the circulation is established. The cause of this shock is debated. Dr. Blalock pointed out that this phenomenon was due to plasma loss into the injured area.<sup>13</sup> Lapchinsky and others have reraised the possibility that a toxic substance elaborated in the ischemic extremity is released into the circulation when the extremity is revascularized.<sup>6</sup> The bulk of experimental evidence is that the explanation for the cardiovascular collapse which is occasionally observed after revascularization is due to plasma and fluid loss into the extremity and wound. It is clear that there is return of blood with a relatively low pH from the extremity.<sup>14</sup> This is, to a lesser extent, the phenomenon that has been nicely described by Dr. Mansberger some years ago.<sup>15</sup> Even with long periods of single extremity ischemia, the result to the systemic circulation in terms of pH is not catastrophic and, in fact, usually not measurable.<sup>16</sup> Nevertheless, the necessity for giving fluid and occasionally for using bicarbonate or amine buffers should be kept in mind.

### Late Complications

The late complications which have resulted in failure are due to faulty or incomplete neural regeneration. In at least one patient, pain beginning in the relatively early postoperative period was sufficiently persistent and severe that reamputation was indicated a few weeks after the original procedure.<sup>17</sup> Obviously, an anesthetic, useless extremity with no joint function is a hazard to the patient and should be removed. It is important to realize that the function of a replanted extremity should be compared with prosthetic function and not with normal.

The definition of success in replantation is difficult. For purposes of this review, I have arbitrarily decided that if the patient and his surgeon agree that the extremity function is preferable to a prosthesis two years after injury, the procedure is considered a categorical success.





Figure 2: Bilateral upper extremity traumatic amputation. Arms are illustrated after extensive irrigation and cleansing. Contusion of the right forearm is also visible.

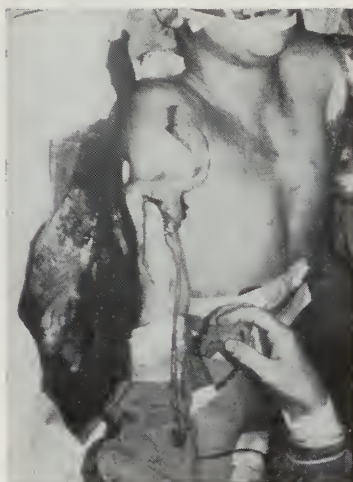


Figure 3: Right amputation site in patient with bilateral traumatic amputation. The extent of nerve avulsion is demonstrated.

Using this admittedly inadequate criteria, about three fourths of the reported cases have resulted in a successful outcome.

My personal experience with replantation, like that of most others, is limited. In December 1969, an 11-year-old boy was grinding hog feed in a hog pen in Wichita Falls, Texas. Somehow, his arms became entangled in a conveyor belt and both arms were amputated and dropped into the hog pen. The boy was flown to Oklahoma City, arriving less than two hours after his injury. On arrival, the patient was in good general condition. Despite massive contamination of the wounds and principally because of the age of the patient, a decision was made to attempt replantation. All wounds were cleaned, irrigated and debrided (Figure 2). The circulation of both extremities was cleared using Ringer's lactate with a small amount of heparin and an antibiotic solution. There were long nerve ends protruding from both shoulder wounds, indicating avulsion-type injury (Figure 3). Replantation was carried out on both sides. Revascularization attempts were completed within eight hours of injury. The left extremity never did well, exhibiting early evidence of venous failure. At fasciotomy several hours after the original operation, arterial bleeding was still present. This arm was reamputated at 48 hours. Massive infection occurred in the right wound. After two weeks, gangrene of the finger tips progressed to the hand necessitating amputation at mid-forearm 18 days after the injury.

The right arm has now been fitted with a prosthesis and the elbow is helpful to him, although it is probably not worth the price paid in

risk and prolonged illness. At least two relative contraindications to replantation existed in this patient. The degree of contamination was truly massive. In addition, extensive nerve avulsion is usually associated with poor nerve regeneration. Faced with a similar situation today, we would probably pick out the better of the two extremities and attempt to replant a single extremity. The procedure is of interest, however, for several reasons. It clearly demonstrated technical feasibility. Also, there were no observed cardiovascular complications.

Our initial experience with replantation involved a 20-year-old basketball player who reached into a commercial water extractor while the machine was still operating.<sup>7</sup> His upper extremity was instantly amputated. An idea of the force involved can be gained from the fact that the patient was not knocked off his feet. His companion was a premedical student (subsequently a house officer in Baltimore) who knew about the necessity for cooling the extremity. The patient was transported 70 miles to the University of Oklahoma Medical Center, arriving about two hours after the accident. The patient was in excellent condition and had sustained almost no blood loss. This extremity was in good condition, having been amputated in a very clean environment (Figure 4). The nerves were avulsed for several centimeters, but the other structures appeared to be cleanly divided. The replantation procedure was carried out exactly as has been described. The extensive comminution of the humerus was repaired by shortening and with multiple screws and plates. Two large veins were anastomosed, followed by





Figure 4: Appearance of amputated extremity. Nerve endings are clearly visible. (This illustration was published in *Annals of Surgery*, Volume 163, page 790, May 1966.)



Figure 5: Appearance of replanted upper extremity 18 months after replantation. Amputation line in the mid upper arm level is visible.

the brachial artery. The nerves were loosely approximated. Muscles and skin were sutured by routine methods. There was never any question about viability of this extremity. The patient showed no systemic effects that we could recognize; however, he did receive blood during the operation. Swelling of the extremity reached a maximum at one week, gradually began to subside over the next several days, and was almost gone at the time the patient left the hospital on approximately his twentieth hospital day.

Subsequently, two operations for repair of nerves were performed. After three months the median and ulnar nerves were repaired—the ulnar using a long graft and the median simply by suture. Later, through a lateral approach, the radial nerve was repaired using a long nerve graft.

At present, this patient has good gross function of his extremity (Figure 5). He has a protective level of sensation in the arm and hand, but it is not very accurate. He knows that something is hot or cold or painful but cannot accurately localize it, and his two-point discrimination is about 2 cm over most of the hand. This is considered preferable to any of the prostheses that have currently been made available.

In summary, replantation ought to be considered in all instances of amputation of the upper extremity. The factors that particularly favor such an attempt are youth and a clean, preferably distal, incised wound. The principal limitation in replantation is inability to obtain predictable peripheral nerve regeneration. Nevertheless, the chances in favorable circumstances of achieving a good result are approximately 70 %.

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# Medical Knowledge Self-Assessment Program

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Historically, medical societies of a general nature were in the forefront and played the major role in providing continuing medical education. This responsibility has more recently been shared with specialty societies.

Medical schools traditionally have not taken much part in continuing medical education until recently. For many years, their main concern was with undergraduate medical education. Following this, they were forced to take on many responsibilities related to graduate medical education. Recently, they have been increasingly involved in sponsoring continuing medical education programs.

The public is also increasingly demanding that medical personnel keep up to date with more continuing medical education.

## **Problems**

There are three main problems concerning the need for continuing education. The first has to do with the rapid expansion of biomedical knowledge. Everyone is aware of this expansion and it does not need further emphasis. However, everyone should be aware of what biomedical knowledge has been developed that would be important to patient care.

A second thing which has increased the demand for more continuing education is the establishment of national standards for adequate clinical care which have been set by various court decisions.

A third very important problem is the increased number of third parties now involved in regulating and paying for the medical care. This has brought into the picture a good many

knowledgeable people who have the responsibility for providing others with good medical care; this immediately assures clinical competence.

## **Components of Continuing Medical Education**

Physicians have traditionally kept up to date with medicine by:

1. Reading;
2. Attending medical society meetings;
3. Attending postgraduate courses (many institutions today which offer postgraduate courses are seeking accreditation by the American Medical Association);
4. Consulting with other physicians; and
5. Employing the newer methods of audiovisual and computerized communication.

The personality characteristics of physicians also play a role in continuing education. The fact that they are generally compulsive, dedicated, energetic, compassionate, conscientious, and sensitive people is important.

## **Missing Ingredients**

The single most important factor in considering any continuing education course is its appropriateness for the physician. How does the individual know what he needs to know if he doesn't know what he lacks? Postgraduate courses are generally designed by those who have something to say and are not necessarily related to the audience's needs. Physicians attend postgraduate courses mainly because they are interested in the subject and they may have only vague reasons for suspecting why they wish to take a certain course.



A second question is how can the physician repair his deficiencies at a time and in the most convenient way when he finds out when he needs something?

### **The Program of Self-Assessment**

**Premises:** After considerable study various committees of the American College of Physicians came to several conclusions:

1. Physicians want to learn and to improve their skills;
2. They would like to know their deficiencies provided no one else knows the deficiencies; and
3. They have varying degrees of paranoia and need careful reassurance.

**Requirements:** The requirements of any self-assessment program were felt by the committee to be:

1. Any such test should be entirely voluntary;
2. It should be developed in such a way that it is convenient for the physician;
3. It should be confidential: no one else should know the results;
4. No records should be kept of individual performance;
5. There should be maximum flexibility for the way the individual takes the examination; for example, by an open-book method in which he corrects his own answers or sends in his answers for computer scoring; and
6. He must have some help in finding answers which was the reason why a bibliography was developed.

### **Method of Preparing the Test**

It was decided that first, it should be a multiple choice test. Second, nine subspecialty areas of internal medicine should be included: hematology, neurology, pulmonary disease, endocrinology-metabolism, renal disease-electrolytes, cardiology, rheumatology-immunology, infectious diseases-allergy, and gastroenterology. Third, nine committees of six physicians each were appointed. One or two of these physicians were expected to be in private practice. In any case, all of the members of the committee were to be involved in the clinical care of patients. Fourth, there were to be 700 questions divided between these areas. Fifth, a

bibliography of reference material for each question was to be developed.

### **Taking the Test**

Two ways were developed for taking the test. A physician, when he finished the test, could send the answer sheets in before a specific deadline. His answers would then be corrected and graded by computer and he would receive the results. The second method consisted of sending the examination material to the physician, with the answer sheets in an envelope which also contained in a separate sealed envelope the correct answers and the bibliography. In this latter form, the physician would correct his own answers.

It was estimated that it would take 10 to 12 hours to complete the test. Actually, experience and comments from physicians who took the test indicate that this was far too little time and most physicians averaged from 18 to 24 hours to accomplish the test.

The cost of this test for the physician was \$15 for members and \$25 for nonmembers in the first edition. In the second edition, it was \$20 for members and \$40 for nonmembers. The total cost of the first Self-Assessment Program was \$128,300 and there was a total income of \$212,500.

### **Results**

When the test was first offered in 1968, 5,000 physicians ordered it and 4,000 returned it in time to have their results machine-scored. Over the next three years, 7,000 additional tests were sent out to physicians, making a total of 12,000 who participated in the first Self-Assessment. Incidentally, no scores of any kind were kept of the group results in the first Self-Assessment.

In the Medical Knowledge Self-Assessment Program II, first offered in January 1971, 10,500 physicians ordered the test. Of this group, 5,000 returned the answer sheets in time to have them machine-scored. Of the 5,000 who returned their tests for machine scoring, 4,000 volunteered to have their scores used in developing group norms. We do not know how many will order this test over the next three years, but it will be offered for that period of time.

### **Group Scores**

Although no individual records were kept of any scores, the summary of how the group did in various categories has been incorporated into a booklet of reference data which is sent to each person who participates in the test. Some of the results of this group scoring follow.



First, the men who were out of school since 1956 generally did somewhat better than the total average. Those who graduated before 1956 did considerably worse, possibly 15 or more points worse in each section, than those more recently graduated. This would be expected because we do know that some physicians took the test who have been out of school for 30 or 35 or more years. Those who indicated a subspecialty interest did considerably better and this varied from section to section, from 10 to 15 points better.

Almost half of the volunteers who submitted their scores for developing group norms indicated that they had a significant enough subspecialty interest that they wished to have their scores counted in one of the subspecialty areas.

Another thing which is provided each participant is a figure to show how many actually answered each individual question correctly. This information is given to directors of postgraduate courses, our Committee on Scientific Program, and to our editors. In this way, if a course is given in hematology, for example, they will know which questions were readily answered by most participants and which were not.

A few other general results of the Medical Knowledge Self-Assessment Program indicate that:

1. About ten other specialty societies are initiating various kinds of self-assessment programs;

2. There has been stimulation of much thinking and activity in expanding this test to get into more definitive clinical competence testing;
3. There has been considerable increase in interest in the American College of Physicians by physicians who never paid much attention to it before;
4. The test has been translated into German and Japanese;
5. It has been used in many residency training programs; and
6. It is used at many meetings and individual questions have been used at staff meetings and in medical journals.

### The Future

This program is a way of protecting the members of the College from obsolescence of knowledge. It will also protect our members against various drives for quality control such as relicensure and recertification. If these in fact do become compulsory, self-assessment tests will certainly be a good way to prepare for them. It also promotes the basic premise that physicians can be trusted to better themselves.

### Conclusion

I can only conclude with a quote from St. Paul's letters to the Galatians, St. James' Version, Chapter 6, Verses 3 to 5. "For if a man thinks he is something, when he is nothing, he deceiveth himself. But let every man do his own work and then shall he have rejoicing in himself alone, and in another."

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Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, May 2, 1972. They must be removed on Saturday, May 6, before 1:00 PM. The Faculty cannot carry insurance on exhibits, but utmost care will be taken of them. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.



HOBBY DISPLAY—Great interest was shown in the Art and Hobby Exhibit at the 1971 Annual Meeting of the Medical and Chirurgical Faculty.





MORRIS N. KOTLER, MD, EDITOR

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## the heart page

# AORTIC STENOSIS

DAVID T. KELLY, MD

Assistant Professor of Medicine  
The Johns Hopkins Hospital  
Baltimore

Left ventricular outflow obstruction is relatively common as it comprises 9% of congenital heart disease.<sup>1</sup> In the child and adolescent three forms may be identified: supravulvular, valvular, and subvalvular.

Supravulvular stenosis is rare and there are two types. The first is an isolated lesion. The second is thought to be related to hypercalcemia in infancy, and may have an unusual facies, mental retardation, pulmonary, and systemic arterial stenosis.<sup>2</sup> Subvalvular stenosis is divided into two groups: discrete (fibrous, and muscular) or fibromuscular. Muscular subaortic stenosis is primarily a disease of the left ventricular muscle manifested as muscular hypertrophy encroaching on the outflow tract and may be familial transmitted as an autosomal dominant or sporadic.<sup>3</sup> These patients characteristically have a long harsh ejection murmur, maximal internal to the apex, and may be confused with mitral incompetence or a ventricular septal defect.

In children and adolescents, discrete subaortic and valvular stenosis is easily identified by the harsh ejection systolic murmur and thrill which radiates to the carotid vessels. The absence of both an ejection click and dilatation of the ascending aorta may suggest discrete subvalvular stenosis,<sup>4</sup> but this can usually only be identified at cardiac catheterization. As this is usually a severe lesion, these patients should have surgery as the stenotic ring is below a normal value and can be easily excised. It occurs with one tenth the frequency of valve stenosis.

Some 85% of left ventricular outflow obstruction is valvular. The severity of this is often hard to determine clinically.<sup>5</sup> The typical

anacrotic pulse is rarely seen in this age group except in very severe stenosis; abnormal splitting of the second sound — a valuable guide — is often difficult to appreciate in the presence of such a loud murmur. The electrocardiogram is helpful when abnormal, but severe stenosis may exist without significant hypertrophy.<sup>6</sup> The chest X-ray is helpful in diagnosis in that a dilated ascending aorta may be present, but is not valuable in assessing severity. Patients with valvular stenosis should be seen at 6-to-12-month intervals and should have cardiograms. If the cardiogram is abnormal, or clinical signs suggest increased severity of obstruction, the patient should be referred for cardiac catheterization. The adolescent boy is often a management problem because he wants to play sports. If doubt exists as to the severity of stenosis, cardiac catheterization should be done as, even if an operation is not indicated, his physical activity can be regulated. Patients with moderate stenosis should refrain from competitive sports, but not be physically restricted completely as this is psychologically harmful in this age group. Operation in this group is not satisfactory and should be reserved for those with symptoms of syncope, angina, or significant dyspnea.

The adult with aortic stenosis usually exhibits symptoms in the fourth or fifth decade and usually has had some minor congenital valve deformity which has calcified causing stenosis.<sup>7</sup> In most instances a murmur suggesting an abnormal valve was not recorded in earlier life. The presenting symptoms are syncope, angina, and heart failure. Patients with heart failure may not have impressive physical signs. Usually



the electrocardiogram shows left ventricular hypertrophy and fluoroscopy calcification in the region of the aortic valve. Cardiac catheterization should be done and, if a significant stenosis is present, those with symptoms should have valve replacement as prognosis is poor.

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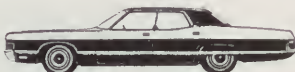
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# Letters to the Editor

Editor:

I think Dr. Morrison completely misses the point on overutilization of laboratory services in general and of gastroscopies in particular.

The proliferation of excessive lab tests rests, I believe, on four foundations:

- 1) The practice of the assistant resident and frequently the attending physician of badgering the intern and medical student with "Did you get a serum 'glunk' and if not, why not?"
- 2) The insistence of the patient that every possible test be done "to make sure I don't have cancer."
- 3) The dictation of medical practice by the mere threat of malpractice so that the

physician feels compelled, *force majeure*, to "cover all bases."

- 4) The AMA "brainwashing" of the public to believe that the SMA-12 and ancillary diagnostic tests can somehow substitute for thoughtful discernment on the part of the practicing physician.

As far as the *caveat* re gastroscopies, with all due respect to Dr. Morrison's expertise, I would suggest that at least equal time be given Dr. Eddy Palmer; certainly my experience is that nowhere enough endoscopies are done, especially in the acute GI bleeder.

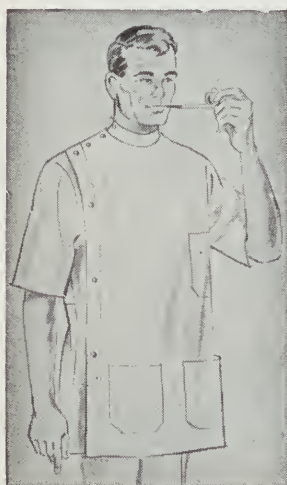
No one doubts that too many lab tests are ordered; Dr. Morrison properly brings this to our attention. However, I feel he could have been less polemical and more informative.

Park W. Espenschade, Jr., MD  
8 Anchor Street  
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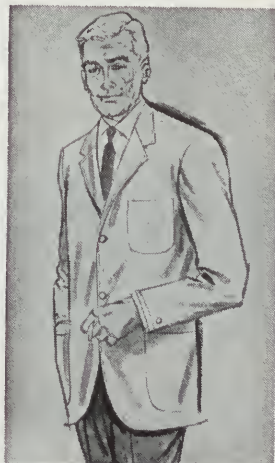
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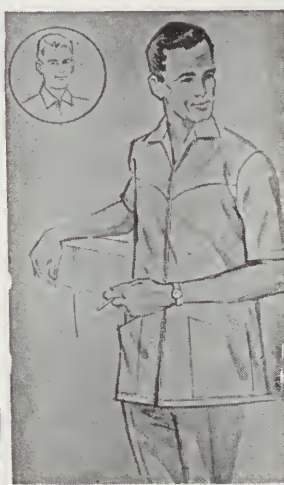
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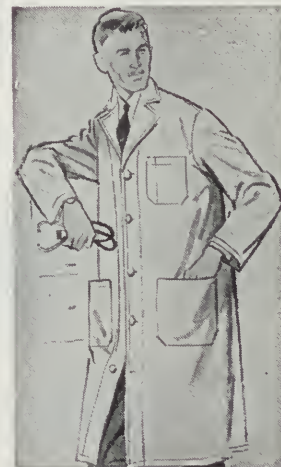
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Ample space is available, however, it is suggested that applications be submitted as soon as possible.

### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee  
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1. Title of exhibit: \_\_\_\_\_
2. Please attach a 50-100 word description of the exhibit: \_\_\_\_\_
3. Give amount of space required, depth, width, and height: \_\_\_\_\_  
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If not, what additional space is required? \_\_\_\_\_
4. Electrical or other requirements: \_\_\_\_\_
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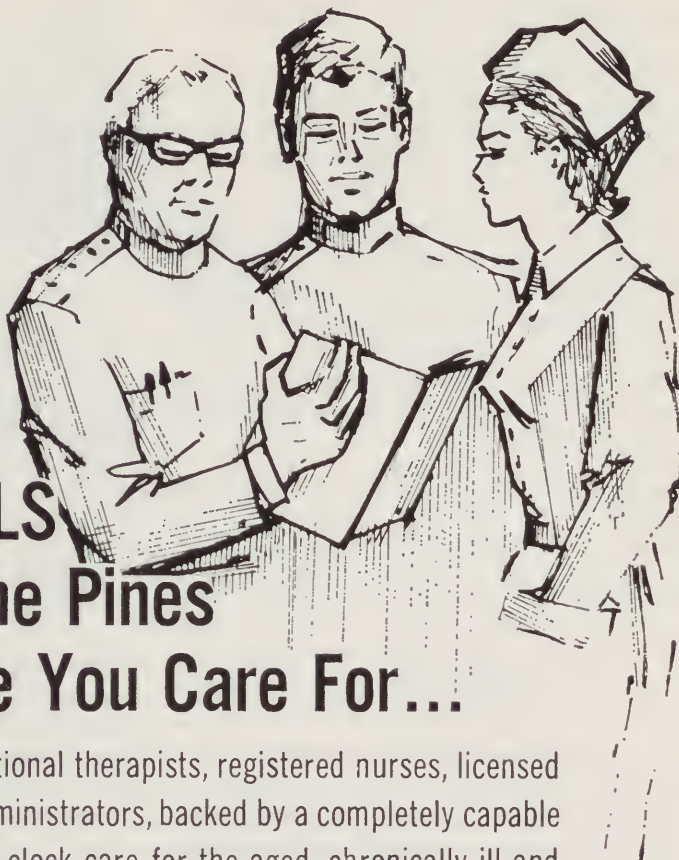
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HEW Secretary Elliot L. Richardson approved a proposed regulation to group medical service to authorize insurance carriers to issue contracts for prepaid persons in any state regardless of any restrictive state law.

Authority for the proposed regulation was granted by Congress last year in a law sponsored by Sen. Edward M. Kennedy (D-Mass) who also is the chief Congressional sponsor of organized labor's all-out national health insurance proposal. Under the terms of the law, the secretary of HEW can authorize insurance carriers who provide coverage through the Federal Employee Health Benefits program to issue contracts for the group medical services.

Forty-one prime health insurance carriers presently provide coverage through FEHBP. The actual number of insurance carriers affected by the law could total in the hundreds because of reinsurance contracts between prime carriers and other insurance providers, according to a spokesman for the department's Office of Group Practice Developments.

The regulation allows the HEW secretary to authorize the insurance companies "to issue in any state contracts entitling any person as a beneficiary to receive comprehensive medical services from a group practice unit or organization" with which the company has contracted for the provision of group services.

The proposed regulation would be to override those restrictions, "enabling insurance carriers to issue contracts for prepaid group



## THE MONTH IN WASHINGTON

medical services to any individual in any state," an HEW announcement said.

HEW said as many as 50 million residents of the 20 states with laws restricting group practice could become eligible for group health plans.

Such plans, as described in the proposed rules, offer preventive, diagnostic, and therapeutic medical services in a single organization on a prepaid basis.

"A medical group . . . shall include at least a general practitioner and representatives of each of the following medical specialties: general surgery, obstetrics, internal medicine, pediatrics and ear-nose-throat," the proposal said.

Kennedy applauded HEW's move but criticized the delay.

The American Medical Association told Congress that the attack on cancer can be most effectively conducted through the National Cancer Institute within the National Institutes of Health, rather

than through a separate and autonomous agency.

Testifying before the House Health and Environment Subcommittee, Franz J. Ingelfinger, MD, editor of the *New England Journal of Medicine* and a member of the Advisory Committee on Medical Sciences to the AMA's Board of Trustees, said that "the effort to cure cancer will have to be a coordinated effort with full involvement of all the national institutes (of health)."

"There is another compelling reason to retain the cancer program within NIH and that is to keep the NIH intact rather than have it become fragmented into independent agencies," Dr. Ingelfinger said.

He expressed opposition to a compromise measure passed by the senate which would create a new independent Conquest of Cancer Agency within the NIH. He said that the autonomy proposed for such a new agency would "threaten the structure of the National Institutes of Health and impair research efforts in all fields."

Dr. Ingelfinger cautioned against expecting any quick victory over cancer. ". . . the American Medical Association advocates a program attacking cancer through greatly intensified and coordinated research efforts. We believe that in the interests of the public and in order to avoid any splintering of efforts, the program, adequately funded, should be administered within the National Institutes of Health under a Director having responsibility for all biomedical research."

The AMA supported



legislation that would provide federal aid to individual or small groups of physicians in establishing medical practices in rural areas, small towns, and low income inner-city areas.

The legislation (\$2269) would amend the National Housing Act to authorize mortgage insurance for the construction and rehabilitation of medical facilities for the practice of one to four physicians in physician-shortage areas. In 1966, mortgage insurance was authorized for establishment of nonprofit group practices. The current legislation would extend that program.

Dr. John M. Chenault, a member of the AMA Board of Trustees, spoke for the Association. He said, "One of the problems in our health delivery today relates to a shortage of necessary manpower, as well as the lack of proper distribution. The shortage is particularly emphasized in rural areas and areas of low income. The failure of such areas to attract physicians can be attributed to many factors — tangible and intangible — and the problem is a complex one. We should, however, provide incentives and encouragement to physicians to meet the needs of those areas.

"In considering these amendments, we believe the provisions in the bill concerning the maximum loan should be reviewed. We recommend that the limitation of \$150,000 should be raised so as not to preclude the establishment of a facility with potentially broad health delivery capability where such facility and staff were warranted in a community.

The figure proposed in the bill might act to limit construction of beneficial facilities in certain areas."

The AMA questioned the desirability of establishing a National Institute for Health Care Delivery.

In a letter to Sen. J. Glenn Beall, Jr. (R-Md), who made the proposal and invited AMA's comment, Ernest B. Howard, MD, AMA executive vice president, said:

"As we understand your proposal, a National Institute of Health Care Delivery would be established, for the purpose of developing improvements in health care delivery, the Institute being perhaps comparable to NIH and NASA. Through the use of 'think tanks' and developmental labs, the institute would examine our existing health care system and design and test components of a new one.

"Our health delivery system is constantly responding to improvements in medicine as they are developed. These changes occur through many means — the medical schools, university and other hospitals, clinics, continuing education (both formal and informal), and community practices of all types. One of the strengths of our health care system is its pluralistic nature which can absorb and respond to changes as new medical and scientific knowledge is developed.

"Your proposal would apparently parallel in many respects the National Center for Health Services Research and Development, only recently created, and it is not clear how the two would relate to each other. Perhaps an expansion of activities of

the existing center should be the vehicle for the contemplated programs."

The AMA opposed establishment of a military medical school.

Testifying before the House Armed Services Committee, Bland W. Cannon, MD, a member of the AMA's Council of Medical Education, said:

"... We cannot emphasize too strongly that our concern is that the men and women in our uniformed services should receive nothing less than the best in medical care. There is no reason why they should not continue to receive care from physicians trained in a medical education system which has proven itself to be unexcelled. We support an expansion and greater utilization of this system rather than the development of a new and different kind of institution...

"One aspect of the nation's goals for more physicians is the need of the uniformed services, and it is to this one aspect that HR2 is directed. The AMA believes it is vital that the number of physicians in the uniformed services be adequate to enable them to carry out their missions, and that those physicians be thoroughly trained and competent in order that those serving our country in the uniformed services might receive the best possible medical care. However, it is doubtful that these objectives can best be realized through establishment of a separate uniformed forces medical school, as called for in HR2. In our opinion, it would be very unwise to establish a separate medical school."



## Letters to the Editor

P. O. Box 204  
Hagerstown, Md. 21740

Dear Sir:

I have read with interest your announcement in the July issue of the *Journal* (page 137) that the "City Has Nation's First Nonfederal Layman to Screen Chest X-rays." It seems that after ten weeks of training a layman can read mobile or other chest X-ray films and thus practice medicine in the State of Maryland without a license. Later he may even give and interpret tuberculin tests.

This is just great! There is no reason, after this precedent has been set, why one should not simply train any layman for ten weeks and then let him read gastrointestinal studies, the films from urological studies, or the films from any other X-ray examination and then let that individual take over radiologic diagnostic practice while the radiologist goes on a vacation — possibly permanently. There is no need to bother obtaining a Maryland Medical License since this precedent of letting one practice without a license after only ten weeks of training has been set by the City of Baltimore and its health department.

Things certainly have changed since I was a Radiology Resident in Philadelphia. The Philadelphia Tuberculosis Association was kind enough to give me a job reading their 70mm screening films but it was necessary at that time for me to be in my third year of training as a Resident in Radiology. According to your article the same city as well as Baltimore now happily accept the readings of a "10-week wonder."

I would think that the cities had better take out some type of malpractice insurance, if they haven't thought of this previously.

If someone turns out to have active tuberculosis at a later date after having his chest film read as "negative" he will certainly bring action against the city for letting an untrained non-physician give him a sense of false security with a negative chest report.

Stanley H. Macht, MD  
Director, Department of Radiology  
Washington County Hospital Assoc.

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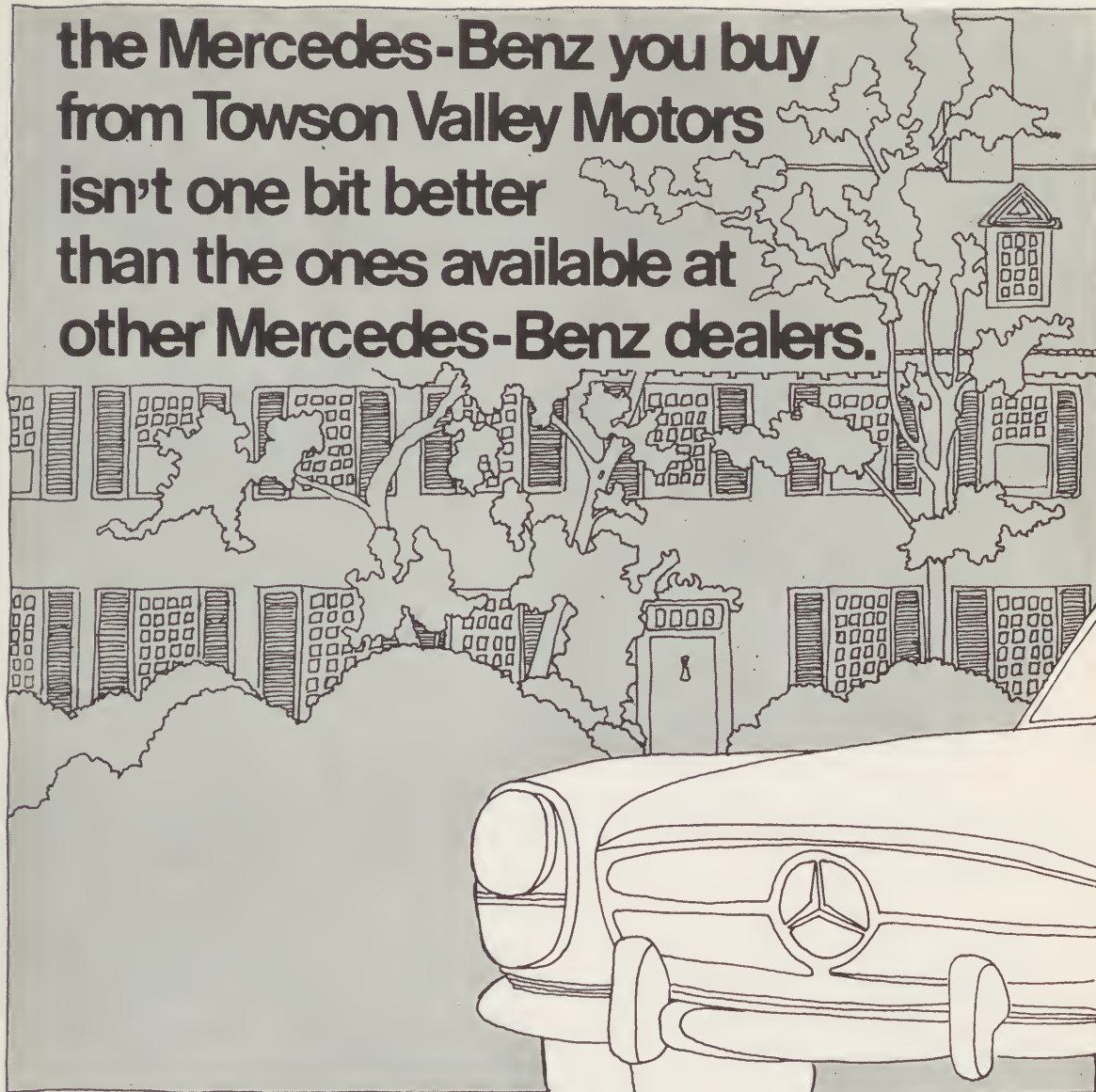
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